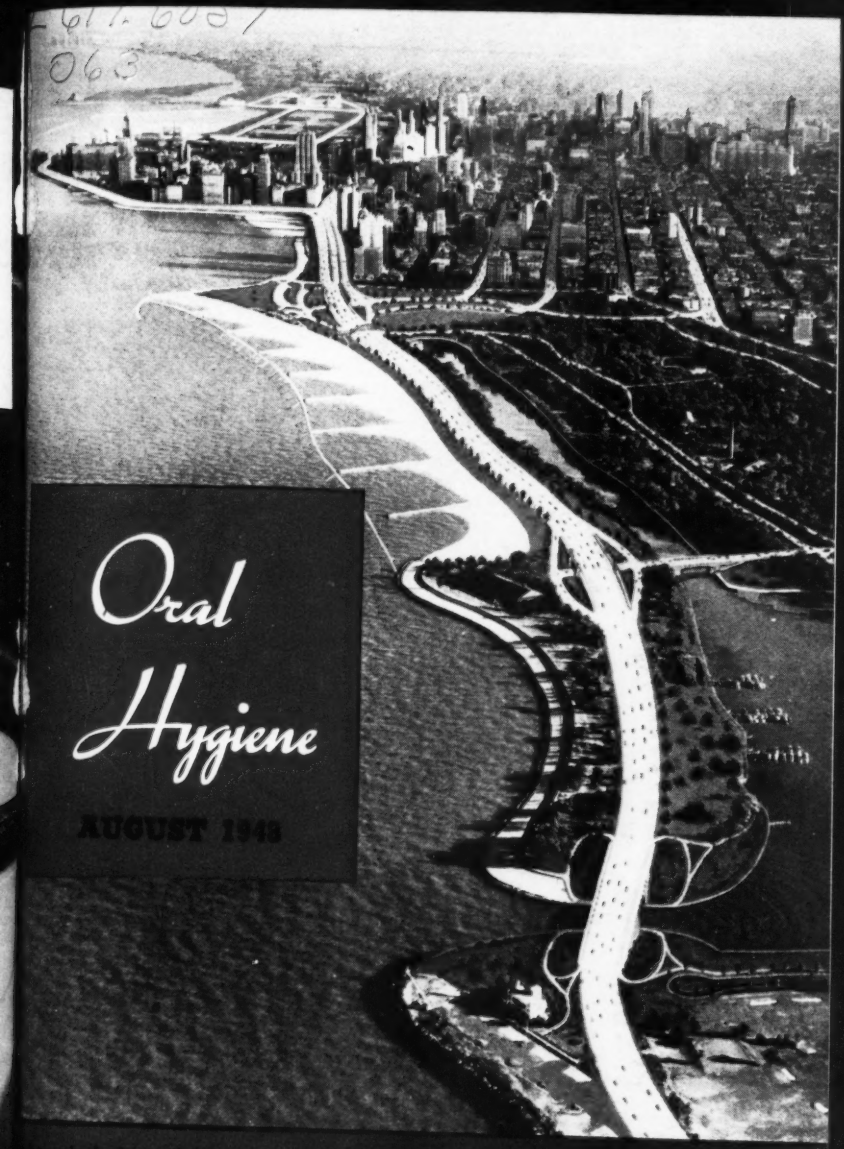
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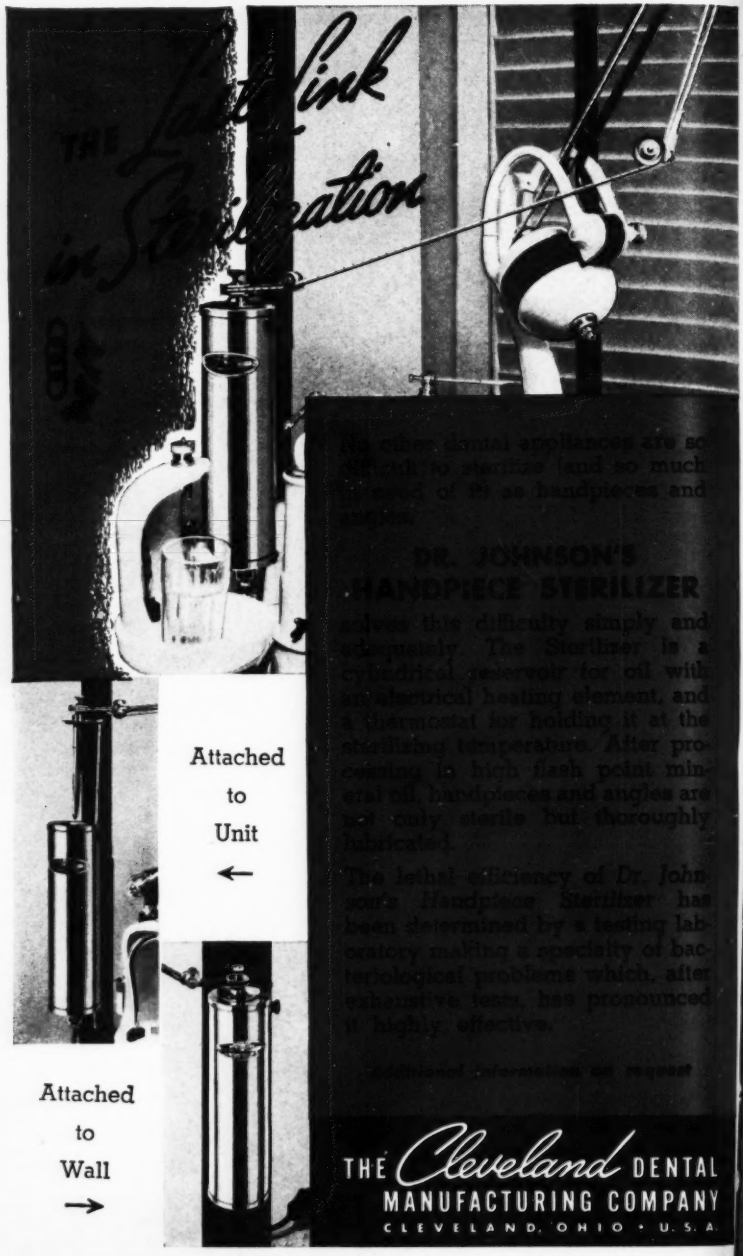
AUGUST 1943

Seventy-Ninth Annual Meeting, American Dental Association, Chicago, Sept. 13-17

In This Issue:

THE DENTIST MUST BE A CONVINCER!

COMPLETE TABLE OF CONTENTS ON PAGE 1041



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The Publisher's Corner

By Mass **Number 325**

SILVER THREADS AMONG THE GOLD

(Dean Moor of Pittsburgh's Trinity Cathedral, who contributed a guest Corner last March, contributes another this month.)

YOU REMEMBER the song. Who doesn't? Not long ago, I heard it sung with a gusto tinged with a touch of autumnal melancholy. The occasion was the meeting of a robust group of men. I looked around and saw many silver threads and I began to wonder where all these men were born, where they went to school, if they had gone to college, what businesses or professions they were in, what organizations they belonged to, what their viewpoint on life was. Was it pessimistic or optimistic, were they expecting life to bring them all the good things or had they the attitude that it was their job to bring something *to* life?

These and many like questions dashed through my mind as rapidly as a car goes under the viaducts on Pennsylvania's Dream Highway.

Are there any silver threads in that hair of yours? If there are, don't let it get you down; if there are not, rest assured there will be someday.

The song begins with the words, "Darling, I am growing old." There is a lilt to the music, but a serious note to the words. Facts are always serious affairs. They should never discourage us, but, rather, encourage us to accept them in a way that is worthy of their seriousness. To handle them with a smile is the height of wisdom. To treat them with either disdain or in the spirit of frivolity is cheap and shows lack of understanding.

It is no easy matter to acknowledge the fact that we are growing old, and that silver threads are sprouting out of the top of our scalps. But there is a certain dignity that should be ours as the years mount up. I don't mean by this that we should become stuffed shirts, for a stuffed shirt is a person without a moral or intellectual or spiritual chest and backbone sufficiently firm and resilient to allow its possessor to stand on his or her own feet. I do mean that, as we grow older, life should be viewed as a serious concern, not a

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cheap affair barely worth considering. Here we are for a few years, and how short they actually are. We should be able to handle them wisely and well. We are entrusted with life by a higher power than our own; we are given life. Our part is to enrich it, make it beautiful, true, and good.

Why not accept the challenge of the years? We are growing old; there are silver threads among the gold, or red, or black, or brown—but don't be dismayed or stampeded. I have more real fun, I get a greater kick out of one hour today than I enjoyed in a month when I was a youth—and I had a very happy childhood and young manhood.

Have you never seen happy folks with threads of silver in their hair and a brave, steady, sympathetic look in their eyes which gives them a luster more vital and radiant than mere youthful exuberance? Who really desires to return to childish faith when he can have child*like* faith, which is a faith based on deep convictions born out of and strengthened in the swirling currents of life? Who, in his right mind, could possibly wish to substitute faith in fairies and Aladdin's lamp for the majestic laws of the universe and the gradual and marvelous unfolding of life?

Let's go on with this thought for a moment. Who would be so craven and unsportsmanlike as to long for a storybook life holding neither a sob nor a sigh? Why, if that were the order of the day, what small and paltry lives we would live, how far removed from the great actualities of life!

No, let's accept the challenge of the years and glory in it. To handle the responsibilities that come our way, to meet the joys with temperance, to find hidden in the deepest sorrow an otherwise undiscovered and undiscoverable strength, to enter into the laughter and tears of our neighbors and lend sympathetic support, to carry our heads with their threads of silver raised toward the heights above and not bowed down in defeat—this is victory.

I salute you, possessors of the silver threads which run through your hair. You wear a badge; make it one of honor and distinction. It has not been pinned upon you by some outer authority; rather, it has grown out of the way you have handled life. Let the silver threads among the gold symbolize the white shining of a great light upon the experience you have gained as life brought you its manifold messages and opportunities.

You and I accept that challenge. You and I face tomorrow trusting in the goodness of God. You and I affirm the innate dignity of man, and, in our small but far from insignificant lives, advance faithfully and fearlessly toward a day which will find more silver threads, rather than fewer, amidst the gold, the red, and black, and brown.

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for ages 21 to 30 consider shades **62, 66**

for ages 31 to 45 consider shades **60, 65, 68**

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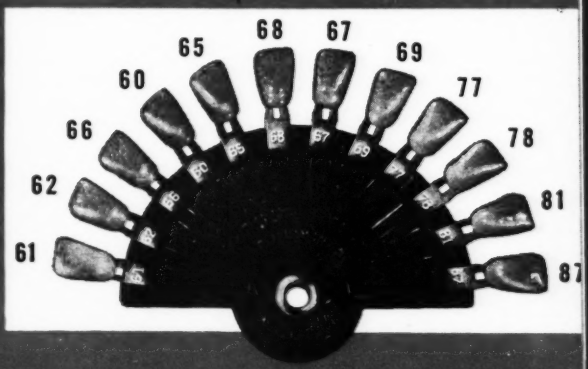
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for ages 61 to 70 consider shades **77, 78**

for ages over 70 consider shades **81, 87**

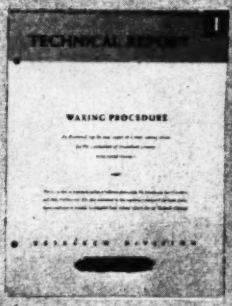
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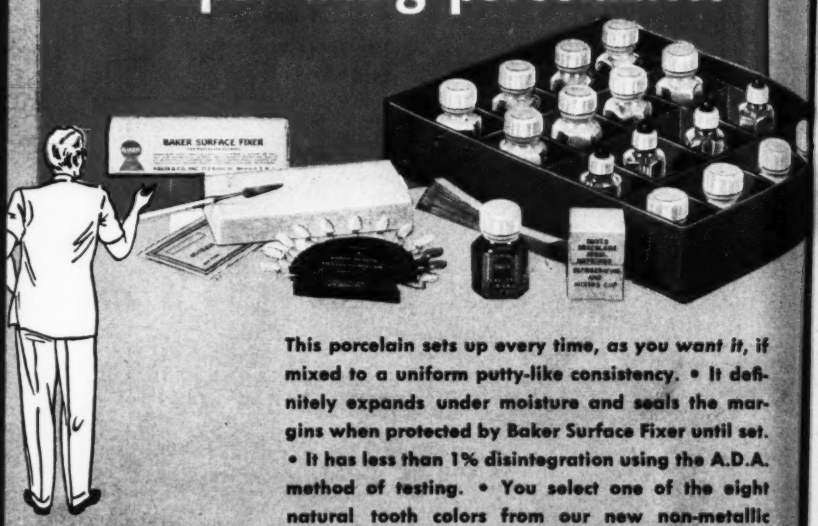
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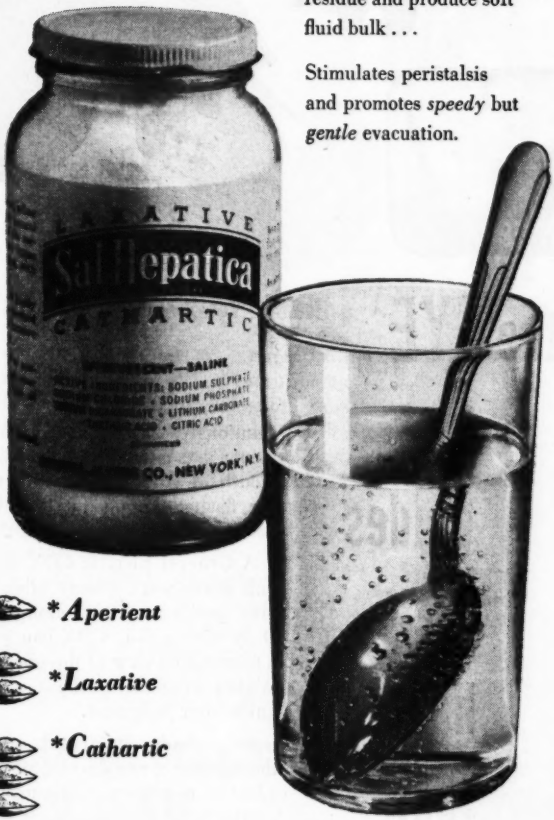


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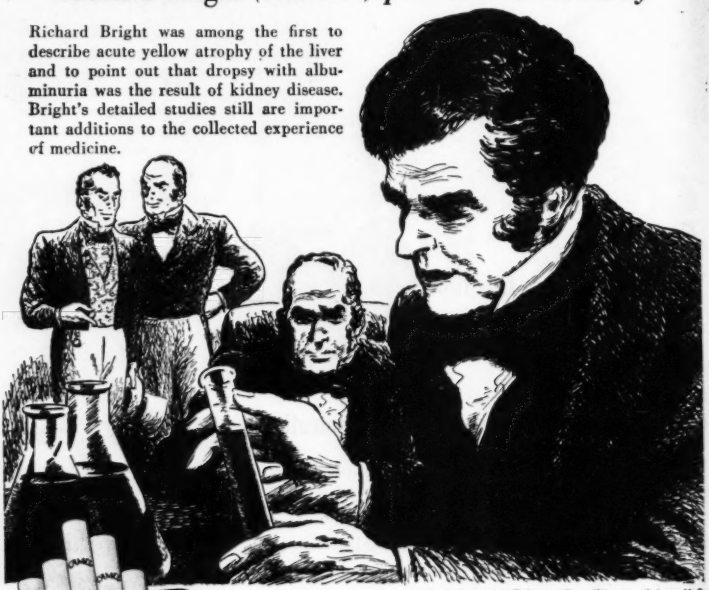
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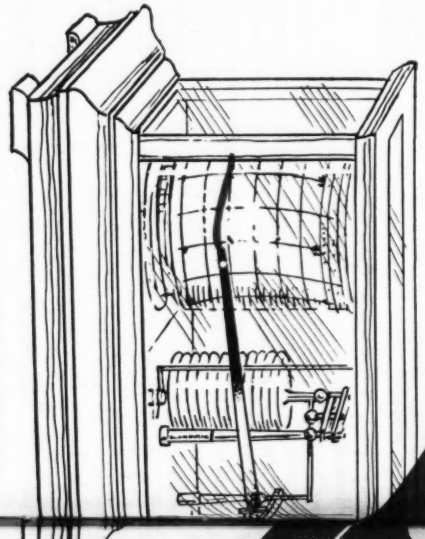
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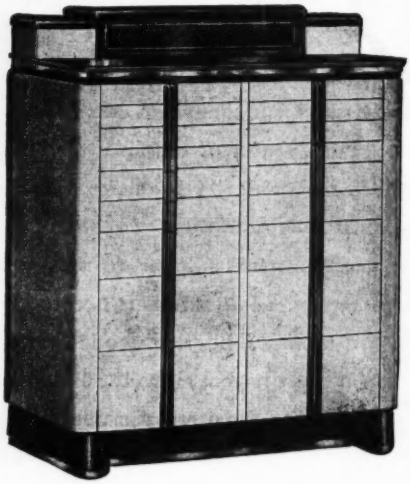


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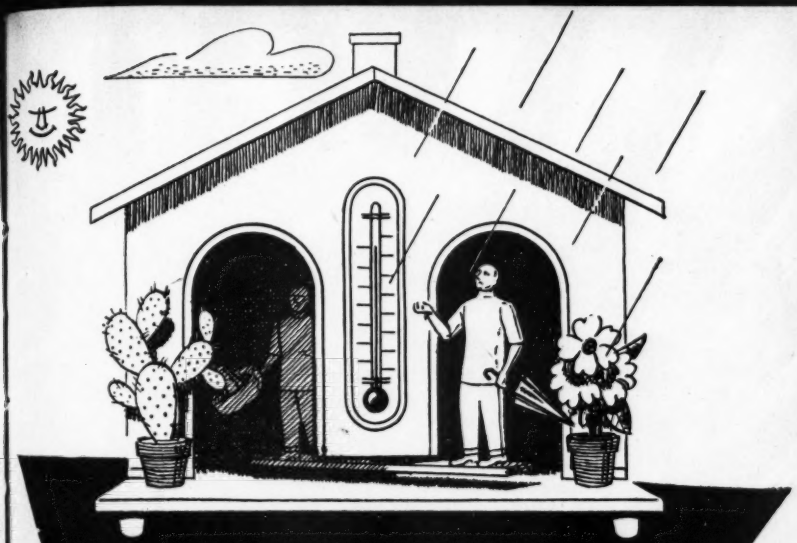
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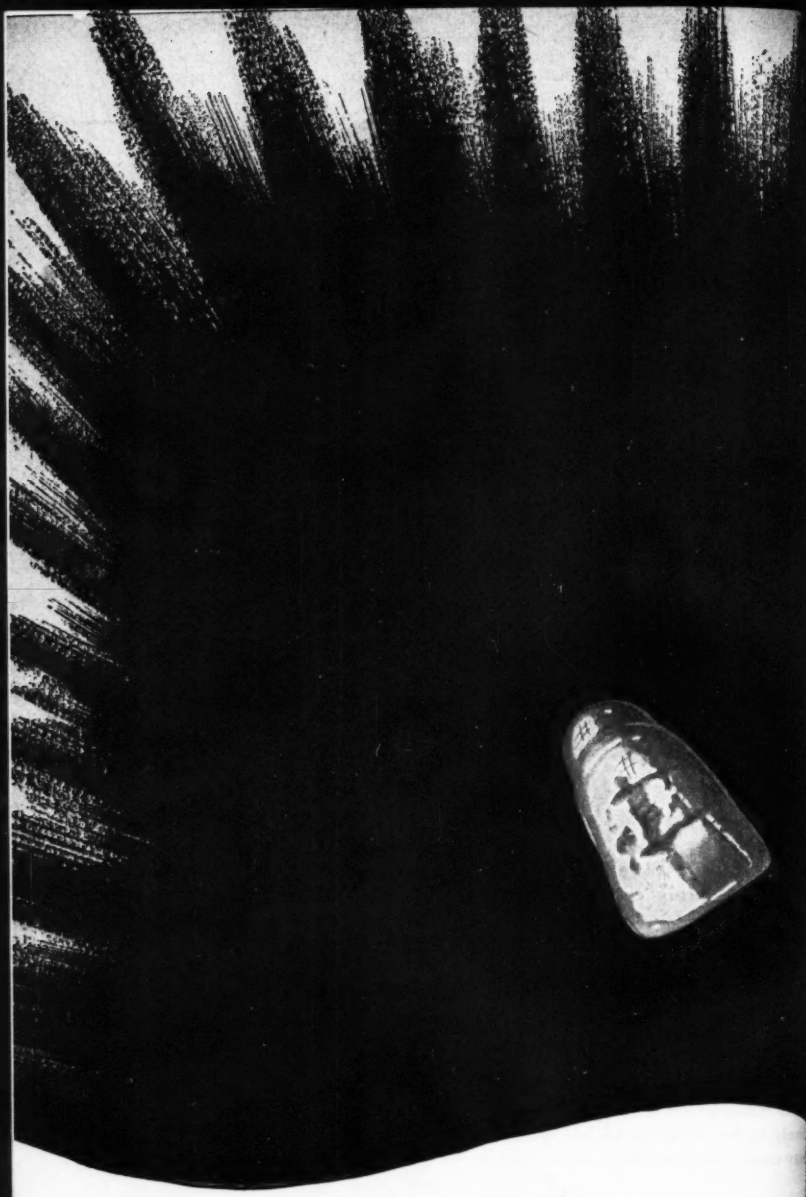
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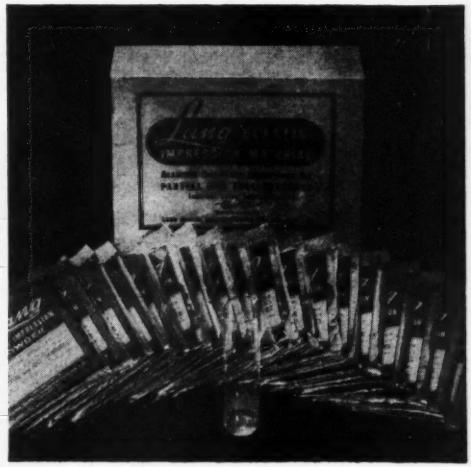
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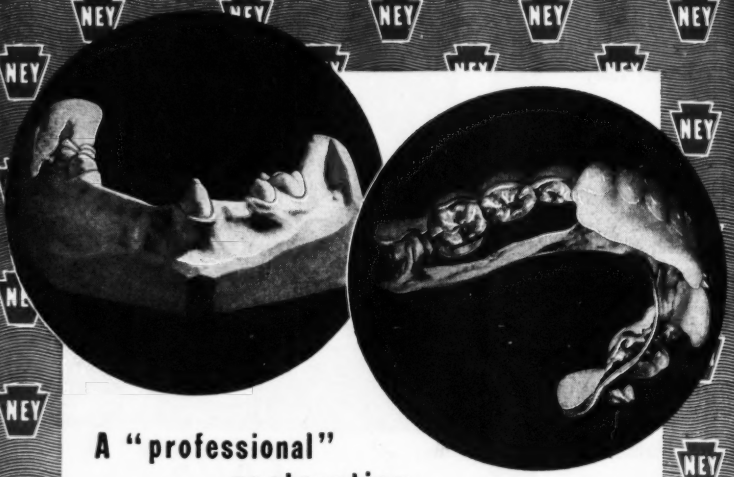
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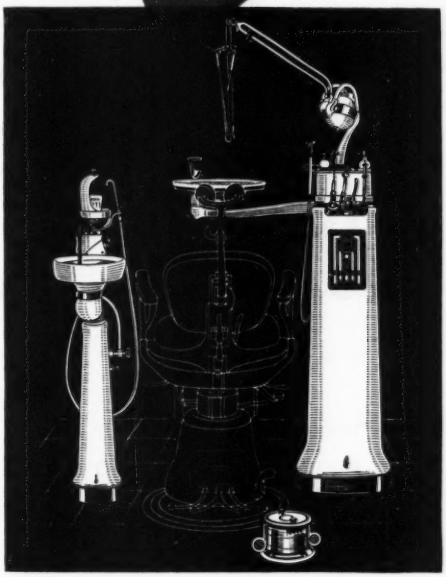
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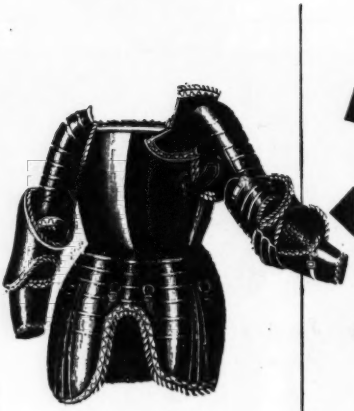
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VOL. 38, NO. 8 AUGUST 1948

Picture of the Month 1229

Death Sits in Some Corners ..... *Thomas A. Carlos, D.D.S.* 1230

The Dentist Must Be a Convincer! ..... *Harold Gluck, Ph.D.* 1234

X-Ray—Furniture or Equipment? ..... *C. L. Meistroff, D.D.S.* 1238

"I'm Confused About Lower Dentures" ..... *Seth W. Shields, D.D.S.* 1244

Perhaps My Sons *Should* Study Dentistry ..... *Hamilton B. G. Robinson, D.D.S., M.S.* 1248

Are You Reserve Officers Ready? ..... *By An Army Reserve Officer* 1252

Portraits and Profiles of American Dentists ..... *Howard A. Hartman, D.D.S.* 1256

DEPARTMENTS

The Publisher's Corner 1202
So You Know Something About Dentistry! 1243
Dentists in the News 1251
Editorial Comment 1258
Technique of the Month 1260
Ask Oral Hygiene 1262
Laffodontia 1266

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Dentists Prefer

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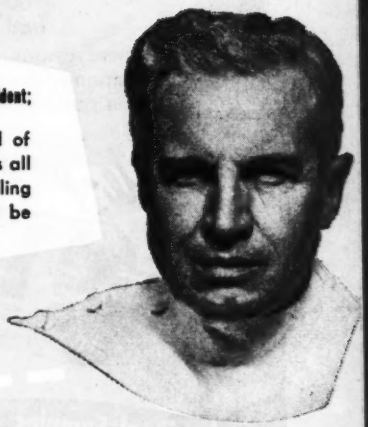
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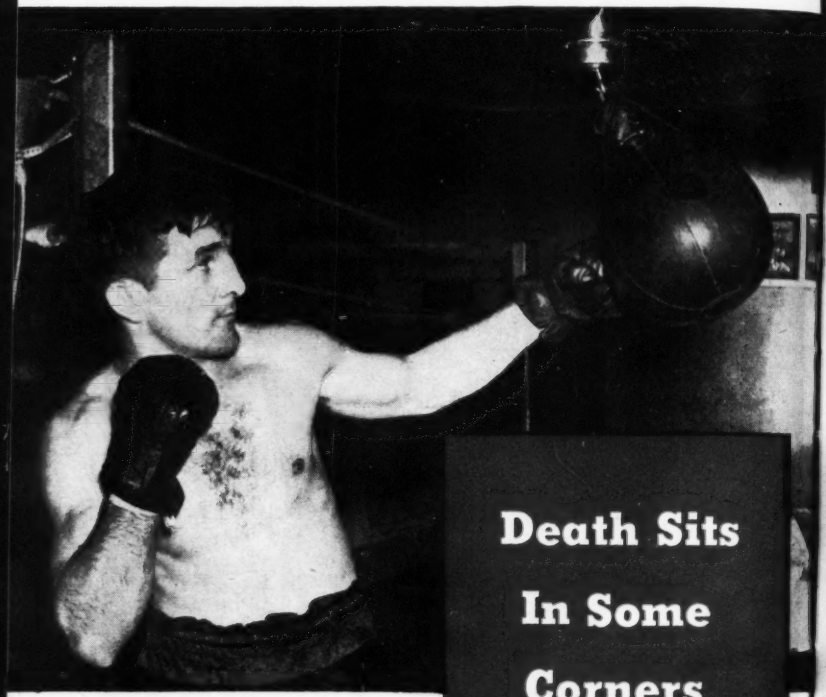
Picture of the Month



THIS OGDEN, Utah, dentist, Doctor H. D. Hull, finds relaxation from his dental office by painting a portrait of his daughter, Sonja. Doctor Hull, who has been an Ogden Palette Club exhibitor for several years, recently won a prize for still-life study in the Utah Centennial Art Show in Salt Lake City. After doing still-life painting for some time, he is now stressing portraits.—*Photograph courtesy of Glen Perrins, Ogden, Utah.*

Ten dollars will be paid for the picture used in this department each month. Send gloss prints with return postage to Oral Hygiene, 708 Church Street, Evanston, Illinois.

Leo Rodak, who has won three Golden Gloves Championships, wears one of Doctor Carlos' specially constructed mouthpieces.—*Chicago Tribune photograph.*



Death Sits In Some Corners

By THOMAS A. CARLOS, D.D.S.

THE CROWD sets up a bedlam. A flurry of blows and one of the fighters is taking the count. "One . . . two . . . three . . . ." But death is not bothering to count them off. It has claimed another victim in a sport that is fast gaining a reputation that will eliminate boxing from the American sporting scene, professionally or otherwise.

With the death of Jimmy Doyle, Sam Baroudi, and another fighter on the West Coast within a few weeks, the public's attention has focused on the fight game. Even Hollywood has produced two films concerned with boxing, and neither moving picture tends to show the game in a flattering light.

Who is to blame in these fatal

Fatal boxing injuries may be prevented through adequate dental consultation.

fights? Is it the promoters who match the men unfairly? Are the state boxing commissions to blame for lax regulation of bouts? Can medical examiners be at fault? It may not be any of these, but experience has shown that the dentist, the man who knows cranial anatomy and jaw structure in particular, is one expert overlooked in the fight business.

A Chicago dentist for twenty years, I have also had considerable experience working in the Golden Gloves tournament sponsored annually by the *Chicago Tribune*.

Head Injuries

I believe that a severe blow to the chin while the mouth is open may prove fatal if the fighter's lower teeth are missing. The only movable bone in the head is the mandible. By a ball and socket arrangement, the condyle of the jaw inserts into the glenoid fossa. The jaw's movements are controlled by muscles holding the lower jaw in place.

When the upper or lower posterior teeth are missing in a boxer's mouth, a severe blow might drive one or both condyles through the roof of the glenoid fossa, into the skull, causing death.

There are two ways to prevent any such occurrence in the ring. Everyone is familiar with a boxer's mouthpiece. Too often the fans have seen it knocked out of a fighter's mouth without being replaced until the end of the round. The mouthpiece does more than save teeth; it acts as a protection against serious damage to the jaw such as has been described.

Dental Examination

But one other safeguard to a fighter's life should exist. He should be examined by a dentist before entering the ring to determine if his teeth are all there and to make sure that his mouthpiece really protects him.

During World War I, many of my friends were stationed at Great Lakes Naval Training Center near Chicago. Since these boys all had boxing experience and fought regularly at the Center, I made mouthpieces of velum rubber for their protection. They were never without the mouthpieces when they fought.

I constructed the mouthpieces in such a way that when a blow on the nose caused hemorrhage and prevented nasal breathing, the boxer could open his mouth and breathe and the mouthpiece would stay in place.

Boxers who wore these specially constructed mouthpieces included Billy Henry, who fought at 135 pounds and won the Jess Willard Belt. Denny O'Keefe, who was a member of America's boxing team in the Olympics, wore one. O'Keefe fought such men as Eddie Fitzsimmons and Jack Britton. Joey Thomas, a former champion of

New Zealand, was equipped with one as were Leo Rodak, Eddie Sparrow, Henry Fuscolds, Dick Sirk, and Young Stuhley.

I placed an interior bridge in Billy Henry's mouth, and to protect it from being knocked out, I made him a mouthpiece. That was the first one I made. Billy wore it successfully in many fights.

Soon after it was made, Billy was matched to fight Mike Dundee in Chicago. Before the fight he looked around his dressing room for the mouthpiece. It was not there. His trainer had forgotten to put it in the bag. Billy went into the ring without it. In the second round Dundee let go with a right. It landed on Billy's mouth and split his lip wide open. In a few seconds he was bleeding so badly the fight was stopped. Dundee won on a technical knockout. Billy would never step into the ring again without the mouthpiece.

Leo Rodak wore one of my mouthpieces in his first Golden Gloves fight. He was never knocked down; neither did he have his mouth cut during the tournament. Rodak went on to win three championships in the Gloves without a mishap.

In a Chicago tournament held in one of the high schools, one of the novices stopped cold after a swift exchange of blows. He turned to the referee, his mouth slack and a bewildered stare glazing his eyes. Everyone knew that the lad was literally out on his feet. The fight was stopped.

★ ★ ★ ★ ★ ★ ★ ★

ORAL HYGIENE AWARD

This article by THOMAS A. CARLOS, D.D.S., *has won the* $100 ORAL HYGIENE *award for the best feature published this month.*

★ ★ ★ ★ ★ ★ ★ ★

I thought something serious had happened to the youngster so I accompanied him to the dressing room. There I placed my thumbs on his lower teeth with my palms under his chin. With downward and forward pressure, I forced the condyles back into position. Luckily there were no serious results from the blow. However, after examination of the lad I found that his lower posterior teeth were missing. The boy should never have been permitted to enter the ring without a mouthpiece.

Special Mouthpiece

A young man was discharged from the Army about six months ago. During his Service career he had done a large amount of boxing. He asked me to make him a mouthpiece. I examined his mouth and saw that his lower posterior teeth were gone. Every time he entered the ring he took his life in his leather-covered gloves. I made an impression of his upper teeth and mouth, and a bite, taking in his lower jaw.

I replaced his missing teeth with a rubber section of the mouthpiece. He could bite into the cushion of velum rubber about a quarter of an inch thick. This acted as a cushion and shock absorber

from a blow. The mouthpiece had suction and it remained in place even when he was forced to breathe through his mouth.

He was to box in Marigold Gardens one night and someone had stolen his mouthpiece. He decided to fight without it and was knocked cold.

I believe that fatal ring injuries caused by severe blows to the jaw which injure the skull could be prevented by having a dentist on the boxing commission with the same powers as a medical examiner. Any boy without a proper fitting mouthpiece should be prohibited from boxing until he has obtained one. The saving of one life would be worth the expense of trying it out. Good mouthpieces and proper mouthpieces can prevent mayhem.

9138 *Commercial Avenue*
Chicago

MEHARRY MEDICAL COLLEGE LAUNCHED BECAUSE OF KIND ACT

HUGH MEHARRY, one of five abolitionist brothers from Indiana Territory, was driving a trade wagon across the Midwest in the early 1870's when a storm overtook him one night. He was found and aided by an old Negro freedman. For this kindness Meharry made a vow to do something for the Negro race. His vow was fulfilled in 1876 when Meharry Medical College, the only all-Negro medical school in the country, was founded.

The idea of a Negro medical college was conceived by William Sneed, a Confederate army surgeon, and George Hubbard, a New Hampshire chaplain and wound dresser with the Union troops, on the battlefields during the Civil War. When Hugh Meharry was asked to supply financial support for such a college, he saw an opportunity to fulfill his pledge to do something for the Negro race. He scraped together $10,000 himself, persuaded his farmer-Methodist preacher brothers to donate an additional $30,000, and the school was launched.

The College received grants from the Harkness Memorial and Rockefeller Foundations. An up-to-date plant was constructed, and in 1923 the American Medical Association awarded the College an "A" classification. Its facilities now include a complete teaching hospital, medical and dental schools, a school of nursing, and training equipment in all other technologies related to the patient. President of the College is M. Don Clawson, D.D.S.

Meharry alumni total more than 5,000 practitioners of medicine and dentistry. It annually turns out more than 50 per cent of all Negro medical graduates. At present it is the only agency in Tennessee carrying on cancer research with isotopes on human beings.—*Chicago (Illinois) Sun-Times.*

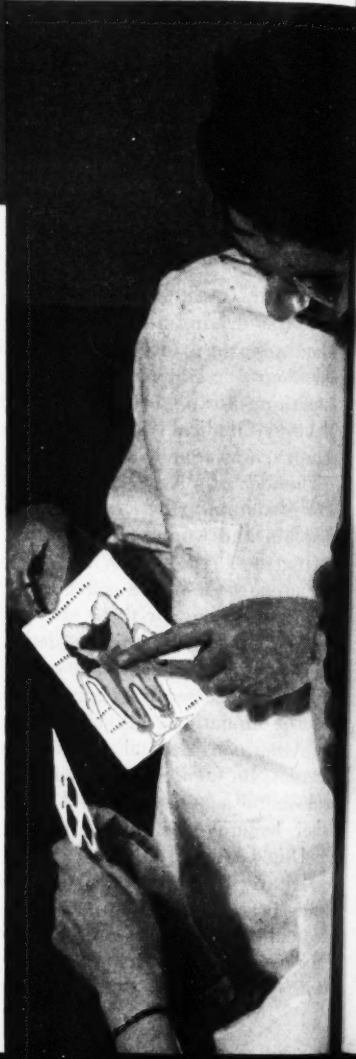
The Dentist Must Be A Convincer!

These suggestions for convincing patients of the need for adequate dental care may be helpful in your practice.

By HAROLD GLUCK, Ph.D.

THE YOUNG dentist who has just finished dental school examines his diploma with satisfaction. He has spent several years in concentrated study and now, for the balance of his life, he has a normal expectancy that he will earn a living in the profession of dentistry. But he already has heard stories, some from the mouths of his former fellow students and others from those who like to give free advice, about the dentist who failed. He wants to avoid mistakes so he makes up his mind that he is going to do the right thing. Unfortunately, good intentions, unless linked with sound and tested knowledge and experience, can lead directly to failure.

This young dentist, as well as the man who has spent years in the practice of dentistry, faces a similar situation which is puzzling. The patient has just had an examination. The examination chart shows the need for five restorations and



one bridge. The amount named for the service seems reasonable. Yet the reply is standardized: "I'll think about it, Doc." And ninety-nine times out of a hundred that patient does not return. Why? That is what puzzles the dentist. He knows that this man has an automobile. When the mechanic says, "Your car needs a valve job," the order is given. When the shoemaker states, "You need full soles and new heels," the shoes are left for repair. The dental treatment is much more important than either of these items; yet the order is not given to go ahead with the service.

Salesmanship

Disappointed, the dentist may say to himself, "What's the matter? Guess I better learn how to be a good salesman." That is a most dangerous thought. For, essentially, the successful dentist is not he who is a salesman, but he who is a convincer. There is a great difference between the concept of the dentist as a salesman and the concept of the dentist as a convincer. Several illustrations will make this important difference clear.

A woman passes a millinery shop. She looks at several hats in the window. Then she enters the store. The saleswoman does her best to make a sale. Her idea is to sell a high-priced hat if possible. Her next effort is to sell a cheaper hat. But her goal is to sell a hat. Imagine what would happen if she said to the woman, "How many hats have you?" The reply, "Seven hats." The answer, "No use wasting your money on one of our hats; you have enough." She would be fired at once.

A man looks at a car in the window of a secondhand automobile dealer. He enters and asks the price. When told it is two thousand dollars, he takes out the money and purchases the car. The salesman is thrilled with that sale. Imagine him asking the prospective customer, "Have you a car that is satisfying your needs?" If he did, his family probably would commit him to a rest home.

There is nothing unethical in selling goods to people without asking them if they need them. That is part of our system of free enterprise. Sell more shoes, sell more cars, sell more radios, sell more shirts, sell more anything. Provided people do not overbuy in relation to their income, they have a higher standard of living in terms of material goods. But this is just what the dentist cannot do! His sale of services can only be made in terms of an actual need.

Ethical Dentistry

A man had his teeth examined by a dentist. Every tooth in his mouth was perfect. The dentist almost had heart failure when the patient said, "Can you put two gold caps on my front teeth? All my friends have them." The dentist spent more than a half hour explaining the effect if such treatment were performed. From the point of view of the salesman, he

talked himself out of a sale. From the point of view of the ethics of dentistry, he was a good convincer, for he had the patient's well-being at stake.

Let us start with this concept of the dentist as a convincer. It is possible to take several situations which can develop in any dental office and see how to handle each of them.

Mother brings in junior for a dental examination. Three "baby teeth" need restorations. But in mother's mind, these are temporary teeth. Why waste money on them? They are going to fall out anyway! The dentist must show by his facial expression how shocked he is when mother suggests this. He then points out to mother the permanent tooth next to the "baby tooth." "That tooth is going to decay," he says in a most determined voice. "Why?" asks mother. In simple terms mother is told how the caries spread in that tooth and contact is made. That *convinces* most parents. It is in terms of the child's well-being. If the one in a hundred holds out, what then? The convincer merely adds, "You say you want time to think it over? The decay won't ask for time to think it over. While you think, the decay works. So there goes your argument!"

Our next situation concerns the average person of adult age and intelligence. A chart is made showing that several restorations are needed. A fee is mentioned. It is important to realize that the person who comes in for an examination has the money. But the mind of the patient reacts by thinking about other items for which the money can be spent. "I'll think about it and see you in a month or so," is the reply. This time the dentist's face has a slight smile on it. In front of the patient he tears up the chart for the examination he has made. This seems a bit dramatic, but it is most effective. "If you came in to see me one month from today," explains the dentist, "this chart would be useless. Hence I tore it up. Frankly, one of your teeth won't stand a wait of a month. Two of them will need larger restorations. Your teeth won't wait, though you may wait. There is absolutely nothing you can do to restore those teeth or decrease the size of the cavities. You can't even stop the decay from spreading. Waiting is useless. Who are you fooling? Shall I begin now?"

"Cheap" Dentistry

This time we face the situation wherein the patient wants the dentist to do the treatment—at the lowest price with "cheap" materials. The patient wants an amalgam restoration; the tooth needs an inlay. Here you may have a duel of words. For the patient may take the attitude that the dentist is trying to "high pressure" him into higher priced dental treatment. Here the dentist as a convincer needs all his skill and art. "I am willing to do what you

want," he says to the patient, "but I want to make one thing clear. Within a period of time, you will come to me or go to some other dentist and have the other treatment performed. You are wasting your money now, because you will spend more for the other service eventually. In addition, you are running certain health risks, and these I want to make clear to you before I begin the treatment."

The dentist must be a convincer because, even today, the average person himself is *not* convinced of the importance of proper dental treatment. I have come into contact with many thousands of people—all backgrounds, all kinds of educational and mental attitudes, both sexes, rich and poor—and this is my sad reaction. They give more care to their car than to their teeth. The new suit or dress is much more important than a new bridge. The old refrain, "Pull 'er out, doc," to many people is a solution. Perhaps this new generation will be different. In the meantime, it is up to the dentist to be a top-rate convincer.

2939 *Grand Concourse*
Bronx 58, *New York*

CLEVELAND DENTAL SOCIETY ORCHESTRA TO APPEAR AT A.D.A. MEETING

ONE OF THE events of the annual meeting of the American Dental Association to be held in Chicago in September will be the appearance of the Cleveland Dental Society Orchestra. This orchestra is composed entirely of members of the Cleveland Dental Society under the direction of Walberg Brown, Orchestra Director for Station WTAM of Cleveland.

The orchestra was organized originally in the fall of 1938 at the instigation of Doctor F. H. Nealon. Its first appearance, after a winter of weekly rehearsals, was made at the Society's annual Spring Clinic Meeting in April, 1939. In 1940 the services of a professional music conductor were procured. It was at this time that Walberg Brown became Director.

The first public appearance of the orchestra was made in conjunction with the Cleveland Orpheus Male Chorus at Public Music Hall in May, 1941. The concert, the "Spring Music Festival," was given during the annual Spring Clinic Meeting.

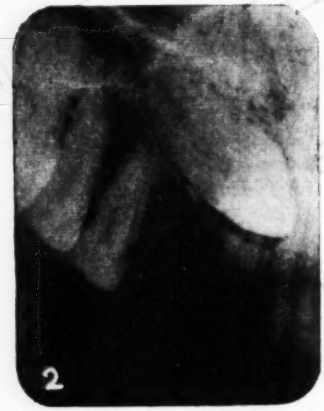
The orchestra's activities were suspended during the war. In the fall of 1947, however, the group was reorganized under the initiative of Doctor Charles Angelotta, clarinetist with the former orchestra. Walberg Brown is again the orchestra's Director.

The first concert of the reorganized group was given at Cleveland Public Hall on February 1, 1948, during Cleveland Dental Society's Children's Dental Health Day Program.

Fig. 1—Two cariously involved pulps too late for salvaging. A condition of chronic periocoronitis existed with sharp recurring pain, but the patient was told roentgenograms were not necessary.



Fig. 2—A deciduous cuspid in place. The patient complained of periodic swelling of the left side of the palate, but was told it was imagination.



X-Ray— Furniture Or Equipment?

By C. L. MEISTROFF, D.D.S.

This dentist believes you cannot provide adequate dental care for your patients without the use of roentgenograms.

THERE IS nothing so stupid in all the practice of dentistry as not taking roentgenograms; going ahead and either doing the treatment or planning it on a blind basis.

There is nothing in the entire practice of dentistry that guarantees so much insurance at such a low rate and is available all the time as is the use of x-ray; but in the office of many well-meaning average practitioners the difference between good service and carelessness can be measured in

Fig. 3—Recurrent caries approximating the pulp. The patient suffered pain from masticating pressure, but was informed that there was nothing wrong with the first molar.

Fig. 4—Residual infection, granuloma, and lingual wall of mandible thinning to fracture point. The patient, who wore an unsatisfactory lower denture which was being relined continually, was told the difficulty resulted from unusual resorption.

the five to eight seconds it takes to expose a film and three to five minutes to develop it. Yet, he shrinks at using this time and would rather tediously pick out root tips or minutely curved apexes under the tuberosity or near the antrum. An exposure would have told him it would have been best to use the straight elevator first and the forceps next—not the forceps alone just because the tooth was loose in the alveolus.

Forty-five to fifty years ago when dentistry did not have roentgenology for assistance, there was present a legitimate professional excuse for "not knowing." But now the story is different. Not to



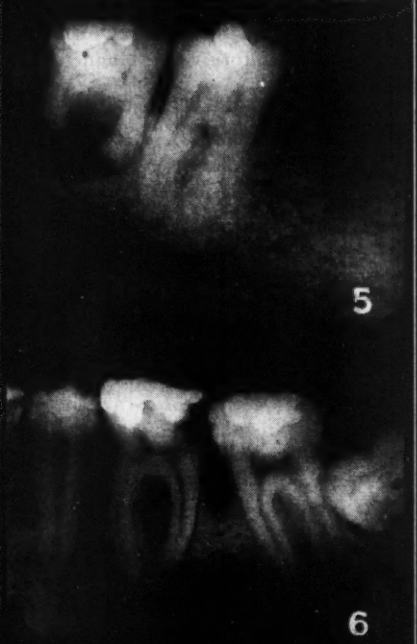


Fig. 5—A large apical area with fistulous drainage. The patient complained of pain in the lower third molar and extending to the left ear, but he was advised that roentgenograms were unnecessary.

Fig. 6—The lower right first molar was restored seven months before this roentgenogram was taken. Roentgenograms were not taken at the time so the proximal caries also present was not discovered.

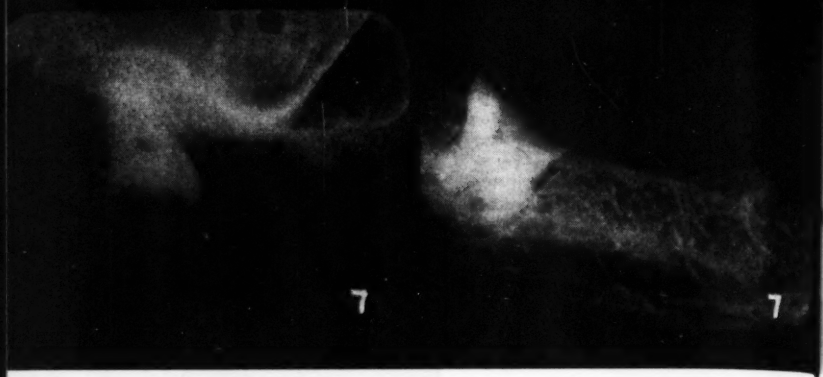


Fig. 7—Two teeth retained by a full-denture patient. The dentures had been damaged by repeated relieving because of soreness in these areas. At no time during the denture service, however, were roentgenograms made.

use the x-ray as a routine measure for a patient's welfare and for the operator's professional expediting is an unforgivable blunder.

Benefits of X-Ray

The utilization of the x-ray in everyday practice is a magician's wand in the operator's hands. At an instant he can see what the problem really is. He will know whether he is justified in making the set of dentures for Mrs. Smith at the fee he quoted. Without roentgenograms will he be caught like he was two years previously when he did not x-ray and later the patient had four third molars start to erupt? He had to make those dentures over gratis after taking out the teeth; he pleaded ignorance because her husband was a lawyer who knew all the answers, some new questions, and virtually all the possible angles.

It is worth while to the dentist and to the patient to show that in taking roentgenograms everything is done for the latter's benefit. If no roentgenograms are taken, or if the necessity for so doing is placed in the category of things nonessential, the entire procedure of dental treatment assumes the role of an easy "racket." The necessity of taking roentgenograms, and explaining to the patient the importance of the part played by this step, will elevate dentistry and that particular operator in the patient's estimation.

Suspicious Patients

Some time ago a local painter came to my office for the removal of several teeth. I started to take roentgenograms. At this he extended his hand and became loud in his objections that he could see no need for them and for me not to try to pad his bill. I informed him that the fee included roentgenographic service. Then I turned to the patient and asked him if it would be possible at some

near date to go over two rooms and some woodwork. He replied that he would be most happy to do so and would see the prospective work as soon as I was through with him at the chair.

I then deliberately threw these same words back at him, telling him that he refused to do anything until he had seen what he had to do in order to estimate properly his charges for time, labor, and materials; yet he objected to my taking roentgenograms that would permit me to perform service for him in an expedient manner and would enable me to extract his teeth inviolably and not "to butcher" him. I asked him, furthermore, why he made flesh and blood issues secondary to paints and plaster? He eyed me quizzically and said, "OK, Doc, go ahead."

Patient Education

The patient does not know what constitutes the true significance of roentgenographic service. Show him past cases where caries located proximally had almost destroyed an entire mouth. Let him see for emphasis. I have on hand a case that I believe is almost the model for a demonstration. It is the full-mouth series of a 20-year-old boy who had twenty-three cavities. Three of the teeth were so carious that the entire crown of each was completely undermined. Yet in the oral examination nothing could be visualized. There was never any past evidence of pain. Heavy mastication caused no discomfort whatsoever. The roentgenograms were the only infallible agency that could reveal this. If nothing abnormal or pathologic is found, this should make the patient feel happier—the same as the completely negative findings in a physical examination.

Few indeed are the patients who would be gratified or delighted to hear their physician tell them that for the $75 examination and all the laboratory tests they have had they can count on a potential collection of kidney stones and a cancer of the liver. They would rather hear that they are in perfect health. They might be annoyed at the fact that they had to pay so much for "good news," but they are glad to get it. The same should be true of the dental patient—a negative roentgenogram should be hoped for—and because nothing of any consequence is revealed, it should not be considered something for which money has been thrown away. That alone is a money-saver and a mental-easer to the patient.

Dentistry cannot advance any more than those who practice it are willing and anxious to move forward with new ideas, research, and technique. Many patients come to the office to have their minds put at ease. What is there in the realm of psychologic dentistry other than x-ray that can be of such great benefit to the patient from both the dental and

mental point of view? What else is there to be done at such little cost?

What does the usual explorer-mirror-picking technique mean? Can caries under restorations be visualized? Can the depth of pockets definitely be determined? Can one be sure that it is *something* under the restoration or inlay of the lower right second molar and not an impacted third molar that is causing the pain and discomfort? We know only too well that even a clean mouth with white teeth does not indicate dental health. Superficially everything is in the best state of being—but we are not interested in surface appearances; the subsurface and what it shows is the real picture. That which we cannot see is the true state of affairs. The sooner dentistry realizes that it has at hand in the x-ray the means of discerning the invisible, the sooner will it be possible for the profession to see its services as it should. The x-ray machine should not be nonproductive equipment occupying office space.

113 *East Grace Street*
Richmond, Virginia

GREATER NEW YORK DENTAL MEETING

THE GREATER New York Dental Meeting will be held December 6 through 10, 1948, in the Hotel Pennsylvania in New York City. The Secretary urges that all hotel reservations be made at an early date through the New York Convention and Visitors Bureau, 500 Park Avenue, New York 22, New York.

The program will include forty-eight registered clinics of one and one-half hours' duration, a new group of essays, topic discussions, table clinics, and visual education films. Several symposiums will be held, and the popular program "In Our Opinion" will be repeated.

THE COVER

OUR COVER is dedicated to the eighty-ninth annual meeting of the American Dental Association which is to be held at Hotel Stevens, Chicago, September 13-17. The striking view of the outer drive leading to downtown Chicago was furnished to us by the Chicago Chamber of Commerce.



So You Know Something About Dentistry!



QUIZ XLVII

1. Patients with long, tapering teeth tend toward a (a) vertical, (b) lateral, mandibular movement. .....

2. Vasoconstrictors in local anesthetics serve to (a) decrease toxicity, (b) extend period of anesthesia, (c) decrease hemorrhage. .....

3. Is a stratum corneum (true horny surface epithelium) ever found in the edentulous human jaw? .....

4. The cementum overlaps the enamel in (a) 25 per cent, (b) 60 to 65 per cent, (c) 90 per cent, of teeth. .....

5. Epithelium is found in (a) 20-30 per cent, (b) 40-45 per cent, (c) 60-70 per cent, of all chronic inflammatory processes of the periapical region. .....

6. Will transillumination reveal areas of periapical infection about the teeth? .....

7. Normally the opening of the mandible from the incisal edge of the upper teeth when the mouth is open is approximately (a) 12 mm., (b) 35 mm., (c) 59 mm. .....

8. Quenching from a high temperature (a) softens, (b) has no effect upon, (c) hardens, gold. .....

9. The combined width of the posterior deciduous teeth is (a) greater than, (b) less than, (c) the same as, the width of their successors. .....

10. Sodium chloride given in large doses by mouth serves as (a) an antipyretic, (b) an expectorant, (c) an emetic. .....

FOR CORRECT ANSWERS SEE PAGE 1261

"I'm Confused About Lower Dentures"



By SETH W. SHIELDS, D.D.S.

I AM CONFUSED about lower dentures!

Ninety-eight per cent of my prosthetic patients appear in my office the day after they get their new dentures with one of the following descriptions of their progress: "Doc, the upper's just fine—doesn't bother a bit, but the lower's:

1. "In my pocket."
2. "In a drawer at home."
3. "In a glass of water in the kitchen."
4. "In my purse."
5. "I dropped the damn thing in the swill on the way to slop the swine early this mawnin'."

Despite the patients' grief with their lower dentures and my confusion, it seems generally agreed today that no treatment within the profession of dentistry causes less difficulty for both clients and dentists than do lower dentures. I have arrived at that comfortable conclusion after hearing lectures on the lower denture at many dental meetings.

Denture Technique

With the modern methods available, it is now possible to make lower dentures, so I am told, that patients can wear, use, and admire. Dozens of tedious techniques are available; time and space permit the presentation of only one.

Take a snap impression of the lower ridge in impression compound that is overextended in all

Are you having the same experience with lower denture techniques that this dentist has?

directions. Chill it, and remove it from the mouth, box with wax and fill with stone. Separate the stone model from the impression and ship it to the laboratory with instructions for the technicians there to cast a metal tray of proper dimensions to enable you, when it is completed, to obtain a secondary impression of your patient's tissues while they are "static." "Static" no longer means the annoying noise that comes from the radio immediately preceding the arrival of a thundershower. It means while they, the tissues, are at rest.

When the metal tray is made and returned to your office sometime during an interval of time that will vary from five days to three weeks, obtain from the supply house what you will find to be an expensive small quantity of powder and liquid impression material with which, after from seven to seventy messy attempts, you still will hope to get a satisfactory secondary impression sometime within the coming nine months. Eventually, one will look good to you. However, do not be surprised if it does not look good to the laboratory.

Impression Taking

The actual taking of the impression, you will discover, will be entirely different from any method of lower impression taking you have used heretofore. The "static" impression materials will not be accompanied with any directions for proportions or manipulation unless a recent change has been made. So simply incorporate and spatulate a certain amount of the powder within a certain amount of the liquid until the mix reaches a certain consistency. Now, load the tray with the mix which you hope you have judged correctly.

Previously, you have filled the patient's mouth with gauze to dry it thoroughly and smeared his face well with a nonirritating lubricant. You have instructed him carefully to remain completely relaxed until you remove the tray.

Remove the gauze and invert the tray. Quickly, and with a graceful, sweeping motion not unlike that of Toscanini calling the kettledrums to action for the battle scene from a hard piece of music, carry the tray into the mouth of the patient. Momentarily, hold it centered just above the ridge. Then let it down softly and gently until the paste you still are hoping you mixed neither too thick nor too thin barely touches the tissues. Release the tray and let it lie. Your patient may close his mouth just a bit.

Formerly our denture patients required and received our undivided attention during impressions. Now we are ordered to ignore them. Therefore, you are excused from your patient's relaxed presence until the impression

is ready to be removed. You remove the tray after it has been in the mouth for five minutes.

We are asked not to become discouraged with this technique after eighteen or twenty thousand failures. Do not get discouraged, then, if your first impressions resemble the petrified footprint of a pygmy jackass. I am advising against discouragement with this technique because you may never get anything beyond your attempts to obtain a satisfactory impression about which to get discouraged.

What you are trying to get, in case you are still interested, is an impression that eventually will lead to a metal base for the lower denture that must be cast in the commercial laboratory.

"Static" Technique

I recall so well my initial efforts to get an impression of a patient's mucous tissues while they were "static." The client was an elderly man, and he had a well-established case of Parkinson's syndrome. This unfortunate condition is characterized by the fingers and thumbs of both hands constantly moving much as if they were attempting to roll pills. The man had not shaved for several days, and the movements of his lower jaw simulated the movements of his fingers. Nevertheless, he was told to relax completely. That is what I had been told to tell him. The loaded tray was placed in his mouth, and I went next door for a chat, a smoke, and a coke with my good friend the druggist.

Upon returning to my patient five minutes later, I became the party of the second part of a situation to end all situations. The man had the tray in his hand. The impression paste concealed his whiskers in their entirety, and had hardened until it resembled the consistency of a well-condensed, gold-foil restoration. His tragic expression was that of one who had just been told by a competent but tactless diagnostician that he had an inoperable cancer.

He immediately demanded to know if he could get his new teeth that same afternoon. I told him he could not. Being a man of my word, he did not. He does not have them yet.

The next "static" case was much more interesting. After six weeks and twenty-nine attempts, we made an acceptable impression of the patient's lower ridge while the tissues thereon were "static." This was the ideal case because previously he had had several failures constructed for him by conventional methods.

After the metal base arrived from the laboratory, a bite-block was constructed, centric occlusion registered, and the models mounted on the articulator. Teeth were selected, set up, tried in, bragged on, and the case processed, remounted on the articulator, and spot ground until a good balance was observed. The beautiful, completed, acrylic, "static" denture was carefully placed in the pa-

tient's mouth, and the assistant and I stood clear of the chair waiting for the patient to go into spasms of ecstasy.

He said it hurt. Obviously, he was mistaken.

That was several months ago. I saw him recently for the first time since his "no-pressure" denture was constructed. He was getting along fine! Far better than either he or I ever expected that he would the day we placed that lower denture in his mouth. Of course, he was wearing one of his old lower dentures and it was functioning beautifully.

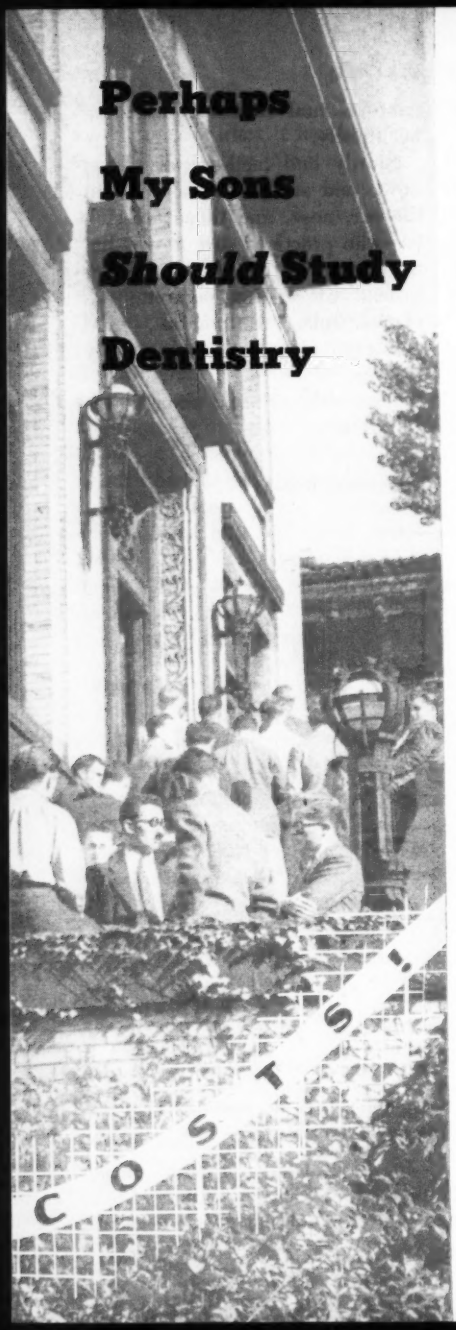
Slowly and methodically I sat down and started thinking about the ear, nose, and throat specialists who practiced surgery for humanity and a living for themselves instead of writing cigarette advertisements, testimonials, and prescriptions for their daily smokes.

I am still confused about lower dentures.

Seymour, Indiana



"It's a package from Mr. Mullhall—in fact, I think it *is* Mr. Mullhall; he'll go to any lengths to get in to see you before his turn—"



Perhaps My Sons *Should* Study Dentistry

By
HAMILTON B. G. ROBINSON, D.D.S., M.S.

IF EITHER, or both, of my sons want to study dentistry, and if they can qualify for dental school, I believe that they should have the opportunity. Many dentists question the wisdom of sending their sons through dental school under conditions of today. They seem to forget that, fortunately, a diploma in dentistry is neither a social insurance policy nor a union card. The diploma bestows certain privileges and imposes certain obligations upon its recipients.

Many years ago dentistry was an art learned from master craftsmen. Gradually, through the efforts of pioneers like Hayden, Miller, Black, and their students, dentistry has developed into a profession that, in large part, is an applied science. As a result, dental education and dental care have developed and expanded. The young men who went through dental school in two or three years on the foundation of a high school education could restore, extract, and replace teeth. Their practice and study placed American dentistry at the highest technical level, but they, as members of the health professions, cannot be compared with the young graduates of today.

It is true that many of those educated on the old basis have developed into excellent professional men; leaders who have helped push forward along scientific fron-

tiers. However, training young men to understand the reasons for using newer therapies, to diagnose the oral diseases that we understand today, and to evaluate the ideas, drugs, and techniques that will be suggested tomorrow, requires more time and better teaching if we are to accomplish these objectives without lowering the standards of their technical training.

Many of the ideas, drugs, and techniques presented by individuals posing as scientists, as well as by those who admit that their sole interest is financial return, confuse the older dentist because he has no foundation on which to erect his thoughts and evaluation. The well-trained new graduate can often analyze these presentations in a scientific manner that separates the wheat from the chaff. As time goes on, and the search for the panacea continues, the need for this training will increase. I have seen dental students locate flaws in published articles or advertisements that have dazzled their more naïve elders. We must go backward or go forward. There is no stasis.

Educational Costs

Dental education now costs more than it ever did before. Certainly it does, and it costs more for food, clothing, housing, luxuries, and for medical and dental care. Wages are higher, salaries are higher, and dentists' incomes are higher. Dental education costs more, but, unlike many other services and commodities, it is better and worth more. Most of the increased cost of dental education is in the supplies, room, board, and clothing; not in tuition. Too many parents are thinking in terms of 1910 dollars when they send Johnny off to school.

Entrance requirements are higher because competition is keener. Dentistry should be proud of this new distinction. Intelligent, capable, hard-working boys are becoming aware of the advantages of dentistry. Why? Because dentistry as taught today, on a more scientific basis, offers a challenge that appeals to keener minds. Because dentistry has taken its light from under the bushel and is publicized, not only through Dentist-Boy Banquets, but through the public press, radio, and public opinion. Predental requirements are still two collegiate years although only superior students make it in that time. Dental school still requires just four years. The average age of nonveteran students is still twenty-four to twenty-five years. Of course anyone who so desires may take a four-year college course and one or more years of postgraduate study.

*Frankel, H. G., Should My Sons Study Dentistry? Oral Hygiene 38:918 (June) 1948.

Yes, I believe my boys should try to enter dentistry if they so desire of their own free will. They should not enter dentistry because they think it would please me or for lack of any other interest.

I believe that we should continue to publicize dentistry through the press, radio, banquets, and by achievement.

I believe that only capable boys and girls should be encouraged to study dentistry because the competition among those making the grade is keen and the less able cannot survive.

I believe that we should continue to reappraise the dental educational system to give our dentists the training they need for intelligent and capable practice. We should offer opportunities to supplement their undergraduate studies with postgraduate opportunities to review, renew, and expand.

I believe that studies of means of supplying the dental needs of the people should be continued on the basis of facts, rather than on the basis of idealistic dreaming. A study of the relative fees of graduates of schools with low tuition and of schools with high tuition probably would demonstrate that educational fees play no appreciable role in the cost of dental care. We need more schools on a geographic basis. Unfortunately, dental education is an expensive field and dental faculties do not develop overnight. With judgment, support, and industry, the needs for dental schools can be met. However, more schools and more dentists are not the answers to the social need.

Why should my boys study dentistry? They should not unless they have the desire to serve as members of a profession which is slowly gaining its full stature by its accomplishments, unless they are willing to study hard against keen competition, unless they can earn their own places in a dental school. Of course they may be disappointed because they were not among the chosen, but would I want them to be accepted if they were not capable of completing the training?

Yes, competition for dental education is keen despite expenses, longer training programs, and relatively small increases in financial return. Dentists should be proud of these signs of acceptance of their profession and proud of their sons who do become successful practitioners.

Ohio State University
College of Dentistry
Columbus, Ohio

WHEN YOU CHANGE YOUR ADDRESS

WHEN YOU change your address, please always furnish your old address as well as the new one. If your post office has zoned your city, the zone number should be included. Please send address change promptly to ORAL HYGIENE, 1005 Liberty Avenue, Pittsburgh 22, Pennsylvania.



Dentists in the News

Long Island (*New York*) *Daily Press*: When Doctor Barnett Halpern, Jackson Heights dentist, telephoned his wife to tell her he had won $500 in the *Sunday Press* baseball scoring contest, he had a hard time convincing her that he was not fooling. "You know I won't bite on those jokes any more," Mrs. Halpern said. Her husband has built up a reputation as a practical joker, but this was no joke since he really had won the contest.

Doctor Halpern was busy operating on a dental patient when the message that he had won the contest was delivered to him. After congratulating the dentist on his success, the patient leaned back in the chair prepared for further treatment. But Doctor Halpern was ready to close his office for the day. "No more today!" he said to his patient. "I'm too excited to work. I'm afraid I'd hurt you."

Topeka (*Kansas*) *Capper's Weekly*: The statue of the late Franklin D. Roosevelt which was unveiled in London in the spring may have a trace of Percival Walmsley's smile in it. Doctor Walmsley, a globe-trotting dentist, was the model for the statue. His resemblance to the late President has paid him well. Before posing for the statue, he portrayed Roosevelt in a moving picture.

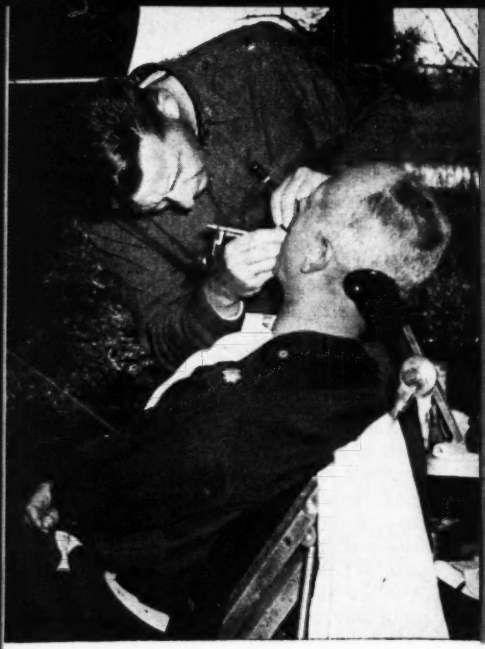


Newsweek: The oldest member of the Doctors' Orchestral Society of New York is 76-year-old Doctor David Gober, a retired dentist who played cello in the Metropolitan Opera orchestra for eight years. He was one of the sixty physicians, dentists, and pharmacists who comprised the ten-year-old orchestra when it presented the world premiere of a new suite, "The Hospital," composed by Doctor Herman Parris. In ten movements, this suite takes a young woman through an appendectomy. Its composer is a 44-year-old ear-nose-and-throat specialist who graduated from the Philadelphia Conservatory of Music before studying medicine.

The orchestra's only paid member is Ignace Strasfogel, its conductor. For public performances, however, the orchestra does have to hire a few professional musicians since its members do not play all instruments. At the present time the orchestra has an orthodontist-violinist. No harpist has ever turned up among the professional members, but violinists in the professions are so plentiful that the orchestra has a waiting list for that section. About ten per cent of the members were professional musicians at one time.

Indianapolis (*Indiana*) *Times*: This year's *Indianapolis Times* Spelling Bee

(*Continued on page* 1255)



Are You Reserve Officers Ready?

By An Army Reserve Officer

IN THE PLANNING for Universal Military Training, draft, or other means of increasing the Armed Forces, we are sincerely interested in avoiding serious injustice and the promiscuous calling to active duty of dentists. The Army and Navy undoubtedly have plans, but we must guide them along sensible lines in this matter.

Editor's Note: The author of this article went into Service as a reserve officer with the Army Dental Corps six months before the attack on Pearl Harbor. While overseas he served in North Africa and with the invasion forces in Sicily, Italy, France, and Germany. He went on active duty as a First Lieutenant and was discharged as a Lieutenant Colonel.

There are many reserve dental officers who have started to practice again after long periods in the Army or Navy, and it is neither logical nor fair to enforce hardship on this group by calling them in for training purposes just for the lack of a screening process. If dentists should be needed, a method that is just and equitable must be considered as the plan for calling men to active duty.

As to the matter of experienced men, I believe we can agree wholeheartedly that we as professional men gain more experience of value to the Armed Forces in our private practice than we could gain if we were in the Service. The Services and the country profited enor-

mously in the last war by this group of privately educated men, men with initiative, men with experience gained from private practice in almost any phase of dental treatment, and the Service will profit again if we should be needed.

A fair plan for the selection of dentists in a program of preparedness, as well as in a national emergency, would seem to be:

1. Call in first those men who were educated at government expense.
2. Call in men according to age and lack of Service in the last war.
3. Finally, those who are older and in proportion to their Service in the last war.

It would also seem proper to give a man credit for overseas service in future considerations of active duty. One should be given credit, before being called to active duty, for twice the time spent in Service for that period spent overseas. The Army and Navy considered this in the plan for releasing men from active duty; now let them consider it in the order of calling men to active duty in preparedness plans.

World War II

Reserve officers in the Dental Corps were ordered to duty prior to the last war and considered it patriotic to go. They could have resigned their commissions and remained at home, many of them for the duration of the war, but they did not. This was an excellent pool of dentists to draw from and it was fortunate that these men were available.

If trust had been kept by the Army and Navy and some small phase, any phase, of prestige had been maintained, that is all the prewar active-duty reservist could have asked. It did not work that way and after the beginning of war on December 7, 1941, the Army had new ideas as to age and rank for those who were nonreservists. This was fair and proper but a little late, and a hardship for those who had been in for awhile. All things considered, and reserves will concur in this I am certain, it was more of a handicap than an asset to have been a dental reserve officer on active duty in the last war.

During a war there is little time for organizational reconstruction to prevent waste of time and effort on the part of personnel, or there did not seem to be time for this in many phases of medical department units. In high-pressure combat areas, there seemed to be necessities for rapid changes. They were made or else annihilation would have resulted. At present we have ample time to plan a better structure of organization for the Dental Corps with the help of the Army and Navy.

We have considered those factors that are fair and equitable in the calling of dentists to active duty. Now let us consider the problems faced while on active duty.

If you should receive orders for active duty tomorrow, would you have eight days to get your affairs in order, rush out of a busy private practice to an Army post, then sit for three and one-half months not seeing a single patient? It happened before the last war.

After being assigned to duty, would you operate in a clinic; one of approximately sixteen men actually treating patients, while two professional men treated no patients and were around to supervise and take care of administrative duties; duties which any high school graduate could care for adequately and which there were enlisted men present to handle? It happened before and during the last war.

If all the chiefs of "this-and-that" in the Dental Corps had been occupied treating patients instead of attempting to keep busy with duties that insulted their intelligence and that of the men around them, there would have been far fewer dentists needed in the Armed Forces. For this reason alone, if the Services should demand 1000 dentists immediately, that number could be reduced to 868 without decreasing service to patients.

If you should remain in this country or go overseas with certain types of units, would you be under the direct command of physicians? The best of the physicians admit that they know nothing of dental problems. This happened during the last war.

The dental officer in the Regular Service must cater to, and in many cases be subjugated by, the medical officers. If the dental officer in the Regular Service could be honest and express such an opinion, he would be the first to suggest and work for separation of the medical and dental branches of the Services. Any thinking person can easily understand that a group of dentists could operate together in full accord without the many chiefs and supervisors.

Men in the Regular Dental Corps have been following a set and obsolete plan; that is, upon reaching certain ranks, they lose out so far as their profession is concerned, because of their lack of contact with it, and become soldiers and administrators. When this occurs, in many cases, they are not capable in the capacity of a soldier, an administrator, or a professional man.

These problems are only sample problems; there are others. The time to solve these problems is now, not when you are on active duty. At that time one becomes only a serial number, a small minority among many.

If we do not work out these problems now, the Armed Forces will work out a plan for us that likely will require the same number of dental officers, but with no consideration for individuals.

DENTISTS IN THE NEWS

(*Continued from page* 1251)

champion was Maynard Kiplinger Hine, 12-year-old son of Doctor Maynard K. Hine, Dean of the Indiana University School of Dentistry. As the Hoosier champion, "Kip" competed in the National Spelling Bee in Washington.

While in Washington, he was greeted officially by Representative Charles Halleck who was acting Speaker of the House the day of "Kip's" visit and who presented him with the gavel which he was using to preside.

Charlotte (North Carolina) News: Doctor Sandy C. Marks, 37-year-old dentist of Wilmington, North Carolina, is leaving a $20,000-a-year dental practice and a beautiful home to go as a missionary to the Belgian Congo, according to the *Winston-Salem (North Carolina) Twin City Sentinel*. There are no dentists in the Congo and Doctor Marks hopes to train natives to practice. His wife and three children will accompany him when he leaves Wilmington in September.

Dallas (Texas) Morning News: In May, 1947, fire destroyed Doctor Robert W. Cagle's combination residence and dental office. He rebuilt and replaced equipment, and less than a year later went to Fort Worth to purchase the last unit for his dental office. While he was there, fire again broke out in the Cagle building; destroying office equipment, household furniture, and clothing. This loss was reported to be approximately $45,000; $26,000 of which was covered by insurance. Short-circuited electrical wiring was blamed for the fire.

Awards for items published in DENTISTS IN THE NEWS this month have been sent to the following:

GERALD WESTREICH, 87-76 Sutphin Boulevard, Jamaica 2, New York.
GRACE M. COOK, 2700 Crawford Avenue, Parsons, Kansas.
HELEN HALBERT, 1122 Market Street, Emporia, Kansas.
WALTER W. MUELLER, Route 1, Bostic, North Carolina.
MRS. WILLIAM MAIER, 1925 Sharp Place, Houston 6, Texas.

CAN YOU USE A DOLLAR?

TO EVERY READER who contributes a newsworthy item, something unusual about a dentist, *which is published in Dentists in the News*, we will send promptly a crisp, new one dollar bill. Every clipping must be taken from a newspaper and carry the name of the publication and the date line. Clippings submitted cannot be returned. When more than one copy of a clipping is submitted, the first one received will be used. Send all items to Dentists in the News, ORAL HYGIENE, 708 Church Street, Evanston, Illinois.

Portraits and Profiles

OF AMERICAN DENTISTS

By HOWARD A. HARTMAN, D.D.S.



Two of the Past-Presidents of the District of Columbia Dental Society are Charles R. Shelton (left) and Llewellyn F. Davis.



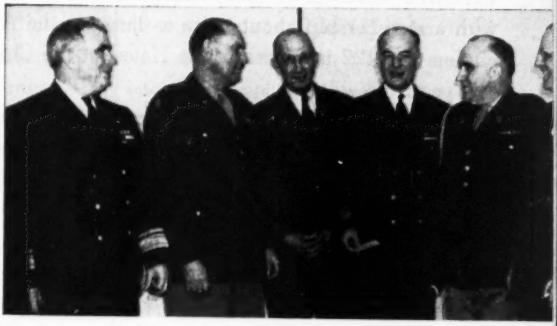
Lower left (left to right): Joseph A. Madden and Howard P. Cobey, Past-President of the District of Columbia Dental Society, dine with John W. Ross, President of the Philadelphia County Dental Society.

Attending the District of Columbia Postgraduate Clinic are John R. Hogan (left) and E. M. Colvin, both of Washington, D. C.





By the use of the mouth mirror, and on exploring, W. D. Postle, Dean of the College of Dentistry, Ohio State University, isolated two molars imbedded in the grounds that are to be occupied by the College's new building; forming a part of the Medical Center. Left to right: Hamilton B. G. Robinson, C. W. Strosnider, Paul C. Kitchin, Doctor Postle, Victor Steffel, and Carl O. Boucher.



Right: Administrative heads of federal dental services are (left to right): Admiral Alfred W. Chandler, Navy Dental Corps; Major General Thomas Smith, Army Dental Corps; Admiral Thomas Wright, Chief, U. S. Public Health Service; Admiral Clemens V. Rault, Navy Dental Corps; Colonel Louis Renfrow, White House Aid and Liaison Officer, U. S. Selective Service; and Edward Kennedy, Acting Head, Veterans Administration.



Right: Gerald D. Timmons, Dean of Temple University School of Dentistry, thanks the alumni and members of the faculty and student body, during the dedication ceremonies of the school's new facilities, for their cooperation.



Editorial Comment

"Give me the liberty to know, to utter, and to argue freely according to my conscience above all liberties." *John Milton*

FEWER DELEGATES MAY BE BETTER DELEGATES

A NEW CONSTITUTION and bylaws of the American Dental Association will be considered by the House of Delegates at the September meeting. One subject that should be given serious debate is a proposal that the House of Delegates be reduced. At the Boston meeting in 1947 there were 372 members of the House. The American Medical Association with a membership about twice as large as the American Dental Association had 122 members in the House at the Chicago meeting in June this year.

The Southern California State Dental Association has passed a resolution that would reduce the House of Delegates by almost half. The Southern California Association "felt that the present representation of one delegate to every 200 representatives results in a very large and unwieldy body in which adequate discussion of measures is difficult: that few states, especially those distant from the place of meeting, can afford to pay the expense of the large delegations now provided; that many delegates selected are not actively engaged in Association activities and are uninformed regarding the problems confronting the House of Delegates; it is felt that a smaller representation, chosen with specific duty in mind and chosen because of qualifications rather than convenience, would more adequately transact the necessary business of the House of Delegates."

The formula suggested by the Southern California Association proposes: one delegate for the first 200 members or fraction thereof; one delegate for the second 200 members; one delegate for the next 400 members thereafter.

Section 90 of the proposed new bylaws of the American Dental Association contains this formula for representation: one delegate for twenty-

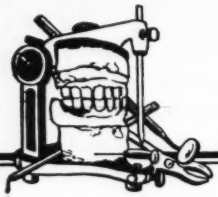
five through ninety-nine members; one additional delegate for the next 200 members or fraction thereof; one additional delegate for each additional 200 members.

For example, a constituent society of 2000 members would be entitled to *six* representatives in the House of Delegates according to the Southern California formula and *eleven* representatives according to the proposed new bylaws of the American Dental Association.

No organization should be tempted to relinquish the privilege of democratic representation. The only valid argument for reducing the number in the House of Delegates is to increase efficiency. A smaller, better informed group might be more capable in conducting the affairs of the Association than a large, uninformed group. Anyone who listened to the Republican and Democratic conventions, with more than one thousand delegates in each, cannot hold a strong conviction that large delegations insure the democratic process. A large delegation is often a hand-picked one and is dominated by one or two political bosses. These political manipulators have the power to swing the entire delegation for or against a measure. The same danger of boss rule is inherent in delegations to the American Dental Association.

If membership in the House of Delegates becomes an honor to be sought and one to be honorably contested for, it is reasonable that better men will be chosen at the level of the constituent society. If, however, the membership in the House of Delegates is to be drastically reduced there should be some guarantee that the constituent society will provide the machinery for the *direct* election of the delegates. In too many states the members of the House of Delegates are chosen by an executive committee or by a House of Delegates within a state society. There is no direct election. Every member of the constituent society should have the privilege of voting directly and by secret ballot (by mail if necessary) for the delegates who are to represent him in the American Dental Association. Much of the regrettable apathy toward the affairs of the Association would be overcome if every member were given the opportunity to participate directly in the selection of delegates—they would then become *his* delegates.

Edward J. Ryan



Technique of the Month

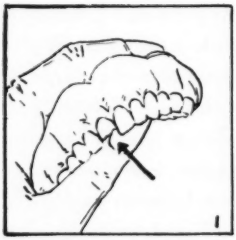
Conducted by W. EARLE CRAIG, D.D.S.

Drawings by Dorothy Sterling

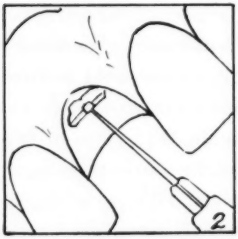
Replacing a Tooth on an Acrylic Denture Without Flasking

By JOSEPH J. SAKMAR

(Reprinted by request)



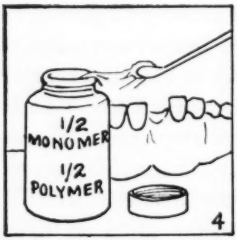
The case: upper right central incisor to be replaced on the denture.



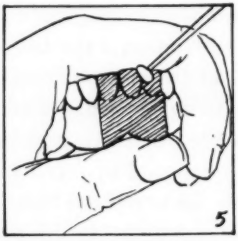
Remove the fractured tooth without marring the acrylic margins. With a bur, hollow out and undercut the area under the tooth.



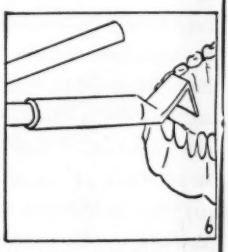
Holding cotton in treatment pliers, paint the hollowed area carefully and thoroughly with pure monomer.



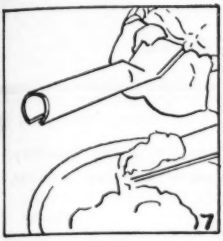
Mix acrylic jell (½ polymer, ½ monomer) 24 hours before using.* Keep in well-stoppered bottle. Apply jell to cavity. Slightly heat tooth and press to place.



Burnish a piece of tinfoil over the three anterior teeth and the labial and palatal side of the denture.

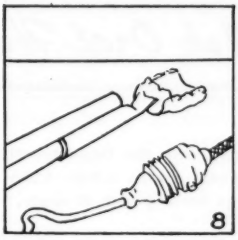


Bend one end of a piece of copper sheet (3½" x ¾" —about 28 gauge) around the heating rod of an electric curling iron. Shape other end over tinfoiled part of denture.

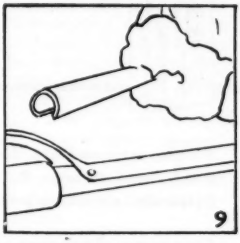


Apply a thin coating of plaster to the tinfoiled area. Seat the copper form and cover it with plaster. Thickness of plaster should be about ¼". Hold in place until the plaster sets.

*Jell may be maintained by adding several drops of monomer once a week.



Insert the heating rod of the curling iron into the groove bent into the copper form. Turn on the current.



Heat for 1½ hours. Turn off the current and air-cool for 15 minutes before removing the plaster and the copper form.

SO YOU KNOW SOMETHING ABOUT DENTISTRY!

Answers to Quiz XLVII

(*See page* 1243 *for questions*)

1. (a) vertical movement. (Tylman, S. D.: Crown and Bridge Prosthesis, Mosby, 1940, page 84)
2. All. (Accepted Dental Remedies, 12th Edition, American Dental Association, 1946, page 50)
3. Yes—covering the hard palate and residual ridge in most mouths where no artificial dentures are worn. (Anthony, L. P.: The American Textbook of Prosthetic Dentistry, 7th Edition, Lea & Febiger, 1942, page 100)
4. (b) 60 to 65 per cent. (Tylman, S. D.: Crown and Bridge Prosthesis, Mosby, 1940, page 91)
5. (b) 40-45 per cent. (Mustermann, H. W.: Principles and Practice of X-Ray Technic and Interpretation, Dental Items of Interest, 1945, page 168)
6. No. (Mead, S. V.: Diseases of the Mouth, 5th Edition, Mosby, 1940, page 581)
7. (b) 35 mm. (Rosenbaum, William: Sclerosing Treatment for Subluxation of Temporomandibular Joint, Am. J. Orthodont. & Oral Surg. 32: 556 [October] 1946)
8. (a) softens. (Tylman, S. D.: Crown and Bridge Prosthesis, Mosby, 1940, page 687)
9. (a) greater than. (McBride, W. C.: Juvenile Dentistry, 2nd Edition, Lea & Febiger, 1937, page 82)
10. (c) emetic. (Accepted Dental Remedies, 12th Edition, American Dental Association, 1946, page 14)



Ask Oral Hygiene

Please communicate directly with the Department Editors, V. Clyde Smedley, D.D.S., and George R. Warner, M.D., D.D.S., 1206 Republic Building, Denver, Colorado, enclosing postage for a personal reply.

Denture Accommodation

Q.—I have a patient, a woman, who wore an upper vulcanite denture for ten years. There was considerable settling of the denture; the bite being closed to such an extent that she looked as though she had no upper teeth when wearing this denture.

I made a new upper acrylic denture, opening the bite 3 mm. The teeth now show normally, and do not seem to be too long. The patient is satisfied with her appearance but complains of lisping; especially when pronouncing words with several "s" sounds such as Mississippi. Is there anything that can be done by me to remedy this situation, or is it a matter of adjustment by the patient?—J. C. F., Pennsylvania.

A.—I would request that this patient make an effort to accommodate herself to the new denture as it is. Tell her that the tongue is a most adaptable organ and that you feel sure that, given a reasonable amount of time, it will accommodate itself to the slightly different form of the new denture.

If, after two or three months, she is still hissing the "s" sounds, I would suggest that you reprocess the case with a set of rugae in the palate. Or try the procedure that one of our correspondents suggested a few weeks ago; place soft impression material in the palate and have the patient pronounce a number of words containing "s" sounds while the material is setting. Then reproduce in plastic the form that the tongue creates.—V. Clyde Smedley.

Fistulous Opening

Q.—About two months ago, a patient, a man, came to my office complaining of a soreness and swelling of the right side of the mandible. He has been wearing full upper and lower dentures for the last five or six years.

I took roentgenograms of the area to determine if there was a retained root responsible for the pain and swelling, and had the patient use hot mouthwashes for about two or three days. The swelling increased in size intra-orally until I finally was able to incise the abscess and secure drainage. The drainage continued day after day in diminishing quantities but there was still considerable soreness which prevented the patient from sleeping at night.

Three hundred thousand units of penicillin were administered on two different occasions during the period after the drainage had been established. The swelling and pain continued to diminish until the patient could wear his lower denture again, but the pain did not completely disappear. I trimmed the denture about three times, trying to make it comfortable, but I was only partly successful.

Today the patient returned to my office after an absence of three weeks. His jaw is swollen again and there is a markedly tender area about where the first abscess pointed. It is possible to distinguish a slight discharge of pus from a fistula that has remained open

since I saw the patient about three weeks ago.

I am unable to see anything in the roentgenograms that I believe might cause this condition. The dentures had been comfortable in the patient's mouth for several years so I do not believe they are at fault.

I shall greatly appreciate your diagnosis of this case and any suggestions you may like to offer.—D. J. K., Nebraska.

A.—The history of your case points to an osteomyelitis, yet your roentgenograms fail to show the characteristic markings in the bone seen in osteomyelitis.

I have encircled a larger area in the bicuspid region in which the bone cortex is extremely rough. Such a rough cortex often causes soreness under a denture but does not often, if ever, result in abscess formation.

I should like to see the film which was centered over the fistulous tract opening.—GEORGE R. WARNER.

Exfoliated Tissue

Q.—A woman about fifty has presented a peculiar discoloration of the palate. She came into my office for new dentures to replace those she is now wearing which are unsatisfactory to her chiefly because of a discoloration of the material.

When examining her mouth with the dentures in place, I noticed that the palatal portion of the upper denture was a milky white so common to discolored clear acrylic. When the dentures were removed to inspect the tissue and ridge formation, I was amazed to see that the denture material was crystal clear and that the white discoloration was the palatal mucosa.

The tissue has the appearance and the dry, leathery touch of leukoplakia. I am not attempting to make a diagnosis, but merely make this statement to describe the condition. The outline of the affected area is identical to the clear acrylic portion of the denture.

I have seen many cases of irritation of the mucosa because of sensitivity to acrylic and poorly fitting dentures, but never have I read or heard of tissue taking on the nature of this one.

I have advised the patient to coat the tissue side of the upper denture with vaseline and to return in a few days. In the meantime, I am anxious to learn your opinion of this case.—A. W., Pennsylvania.

A.—It is not uncommon to find a whitish layer of exfoliated epithelial tissue covering the palate under the upper dentures when patients keep them in continuously and do not brush or rub the tissue with a cloth to keep it cleansed and vigorous. From your description, however, I judge that this is a different condition.

Your suggestion of having the patient keep the denture coated with vaseline for a few days is good, I would say. If this does not bring the tissue back to normal, I would ask the patient to leave the denture out entirely for a week or two. If this does not help, I would have her consult a dermatologist. —V. CLYDE SMEDLEY.

Submaxillary Glands

Q.—Upon the insertion of a partial lower cast denture supplying the four posteriors on either side, one of my patients, a man, experiences extensive swelling of the submaxillary glands. He does not complain of discomfort otherwise. Five hours after the denture has been removed, the glands become normal. There is no impingement of soft tissue. Please explain, if possible, the cause of this condition.—F. W. Z., Pennsylvania.

A.—This case apparently does not make sense where there is no contact with or coverage of the submaxillary ducts.

I think of only one suggestion

as a possibility: It is possible that calculus has accumulated in the salivary duct; creating a partial closure or obstruction. The insertion of a new partial denture to which the patient is unaccustomed causes an increased flow of saliva in excess of what the obstructed duct can carry; causing swelling.

To demonstrate the presence of calculus in the duct, place a film horizontal to the floor of the mouth and make the exposure shooting upward through the gland from beneath the chin with head tilted back.—V. CLYDE SMEDLEY.

Denture Stress

Q.—I am mailing you a model of a patient's lower teeth. I made this patient an upper denture which repeatedly cracked through the center. I have had many other upper dentures crack when the patients had no molars. For this patient, I am to make a new upper denture but I do not know what I should do with the lower teeth. I shall appreciate your suggestions.—J. M. C., Ohio.

A.—I refuse to make a full upper denture in such a case without at the same time making a partial lower to provide an equalization of stress on the upper.—V. CLYDE SMEDLEY.

Deciduous Teeth

Q.—Enclosed are roentgenograms showing the anterior teeth of a boy 3½ years old. He struck these teeth against a frame chair while playing.

The left deciduous lateral was driven back or lingually; the left deciduous central was driven upward into the bony tissue.

The right deciduous central likewise was struck and loosened, and after a week it looks as if it also will become nonvital.

It is difficult to tell, while the swelling persists, how much the labial bone plate has been injured. I am reluctant to extract for that reason.

The lateral incisor has returned to its original position although it is loose. The centrals are "rocky" but not loose.

My interest in this case was heightened by what appears to be a supernumerary tooth imposed on the permanent incisors. Do you think that is what it is? If so, how does it affect the procedure of treating the injured nonvital teeth?

Should they be extracted, or is there any advantage in allowing them to retain their position so long as they do not cause the patient discomfort?—R. H. B., New Jersey.

A.—There is no hurry about treating the 3½ year old boy who has dislodged three of his deciduous maxillary incisors. It would seem, from appearance of these teeth and periapical bone as shown in the roentgenograms, that they are nonvital and will abscess. However, deciduous teeth tend to recover their apparent loss of vitality, so that is why it would be best to do nothing at present.

When it is certain that they have lost their vitality and are infected, they should be removed. It will not be necessary to use space retainers, as the anterior part of the maxilla does not seem to lose dimension because of the loss of deciduous teeth.

You are right in saying there is a supernumerary tooth labial or lingual to the left central incisor. This should be removed in about three years; otherwise, the central incisor will probably not erupt.—GEORGE R. WARNER.

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559. *Facings, jacket crowns that matched perfectly when inserted—appear too light years later—no longer match adjacent natural teeth.*

560. *The restorations did not change color; surrounding natural teeth darkened.*

561. *As the patients became older, color saturation of their teeth increased—a natural physiological occurrence.*

562. *Research on the relation of age to tooth shade shows:*

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563. *A system of shade selection—based on nature's own orderly system of color progression (from light to dark)—is most practical, convenient.*

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★

Two sows were conversing in the pig lot. Said one to the other:

"What became of your bore friend?"

Said the other: "Oh, he hasn't been around—but I had a litter from him several weeks ago!"

★

Woman Driver: "Can you fix this fender so my husband will never know I bent it?"

Garage Mechanic: "No, but I can fix it so that you can ask him in a few days how he bent it."

★

"George and I took a Kodak to Niagara Falls with us on our honeymoon."

"Anything developed yet?"

"Mercy, not yet—we've only been back two days!"

★

Friend: "Was the doctor angry when he was called from dinner to attend those maniacs at the asylum?"

Man: "Oh, no, he merely said, 'from soup to nuts.'"

★

Heard in a Barber Shop:

Sam: "Bill is a new graduate from a barber college, and the college yell is, 'Cut his lip, cut his jaw, leave his face, raw, raw, raw!'"

★

Pledge: "If you're so crazy about the guy, why don't you marry him?"

Sister: "Do you think I want to hook up with a guy who snores all night?"

★

Hubby: "Some day, beloved, I shall die and leave you."

She (very sweetly and tenderly): "How much?"

★

We always called a spade a spade until we hit our foot with one the other day.

★

The little guy strutted up to the bar and ordered two whiskies from the husky bartender. He tossed one down his throat and poured the other in his vest pocket.

The process was repeated six times.

"Say," demanded the barkeeper, "what's the idea of pouring all that whiskey in your vest pocket?"

"Shut up and mind your own business or I'll knock your block off," the runt snarled.

At that moment a little mouse poked his head out of the pocket and growled, "Yeah, and that goes for your damn cat, too!"

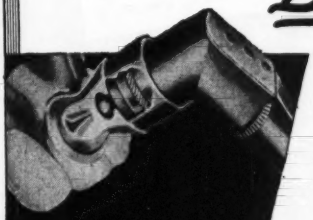
★

There were two skeletons locked in a closet. Suddenly one said to the other:

"Say, Joe, if we had any guts we'd get out of here."

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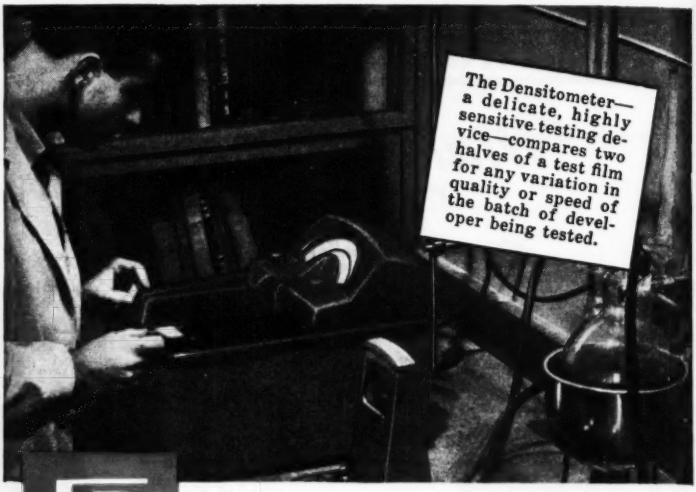
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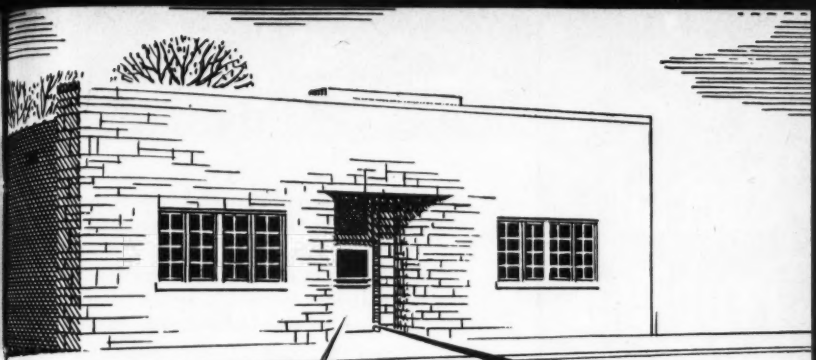
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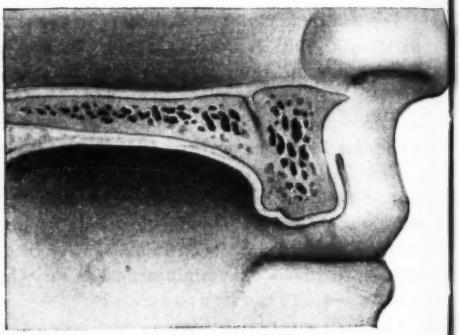
Special Problems in Denture Retention

Reproduction at the right is taken from the Wernet Booklet "Special Problems in Denture Retention" published for the dental profession.

Undercuts and Overgrowth of Tissue

Undercuts and overgrowth of tissue are often sour of denture trouble.[1] Large tuberosities may make difficult to take a proper impression; and the pro nent points of undercuts on the ridges are apt to bruised by the denture.[37] Surgical removal of the bo part may be unavoidable in some cases, but Mille believes that conservative management will be s cessful in many others.

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Cross-section of undercut.

10



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BULBOUS TUBEROSITIES create undesirable undercuts endangering adequate peripheral seal.





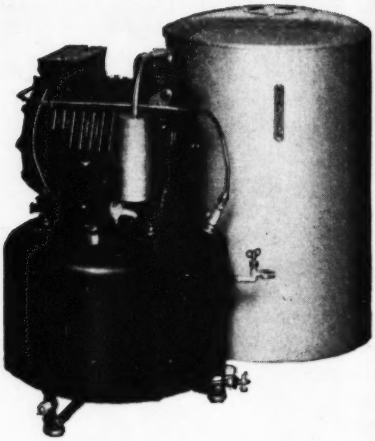
To be protected against pressure, OVER-GROWTHS require reliefs in the denture.

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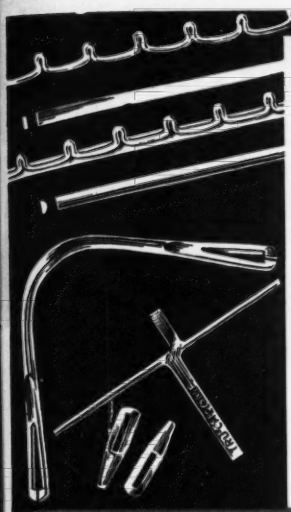


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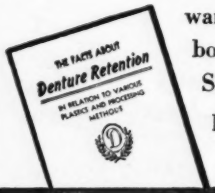
EVER WONDER WHY SOME DENTURES "Act that Way?"

For instance, that "simple" full upper case with a high vault that you thought would provide the maximum of retention—but didn't.

Or the one made from an impression that you *knew* was accurate, but that soon lost its initial snug fit.

The reason for loss of retention in most cases is *warpage.* And warpage is inevitable when plastics—whether acrylic or acrylic compounds—are "cured" in the process of molding.

There is only one way to avoid acrylic-denture warpage. It is explained with irrefutable logic in a booklet we shall be glad to mail you at your request. Send for it now, and be prepared to provide your patients with dentures that "stay put".



The Dresch Laboratories Company
1009 Jackson Street • Toledo 1, Ohio

Please mail "THE FACTS ABOUT DENTURE RETENTION..."

Dr. _____

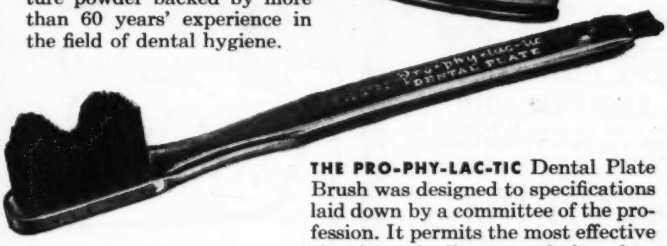
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Help for your Denture Patients



PERMA-GRIP Adhesive Denture Powder can serve importantly to build your patient's self-confidence during the early stages of accommodation to a new denture. Perma-Grip provides exceptional holding power without danger of irritation to delicate tissues. It is made with high quality karaya gum and resists "balling up" under the denture. You can confidently recommend Perma-Grip, the *improved* denture powder backed by more than 60 years' experience in the field of dental hygiene.



THE PRO-PHY-LAC-TIC Dental Plate Brush was designed to specifications laid down by a committee of the profession. It permits the most effective cleaning of *all* parts of the plate without danger of damage to clasps and attachments. Recommendation of a Pro-phy-lac-tic Dental Plate Brush will pay you dividends in extra good-will.

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Yes . . . Waite's Topical Paste gives you the anesthetizing efficiency of famed Pontocaine *plus* the antiseptic qualities of time-tested Zephiran Chloride!

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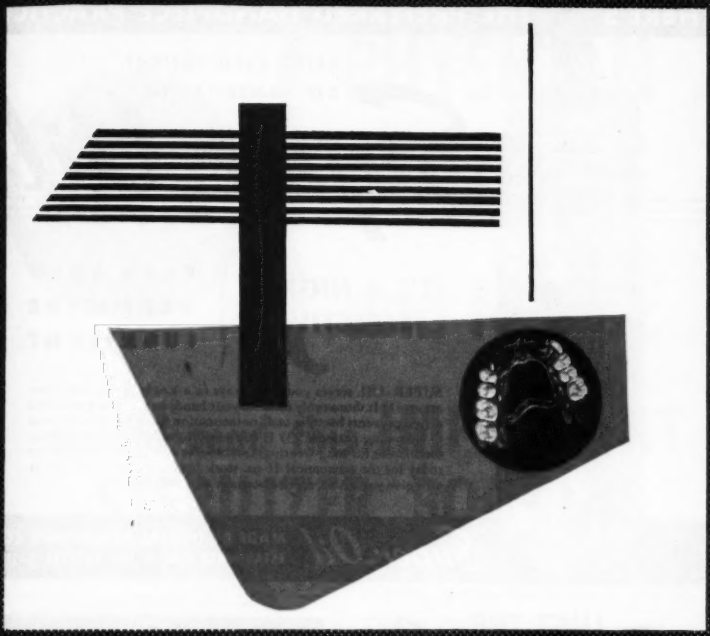
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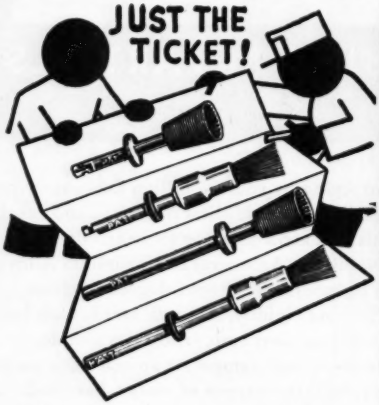
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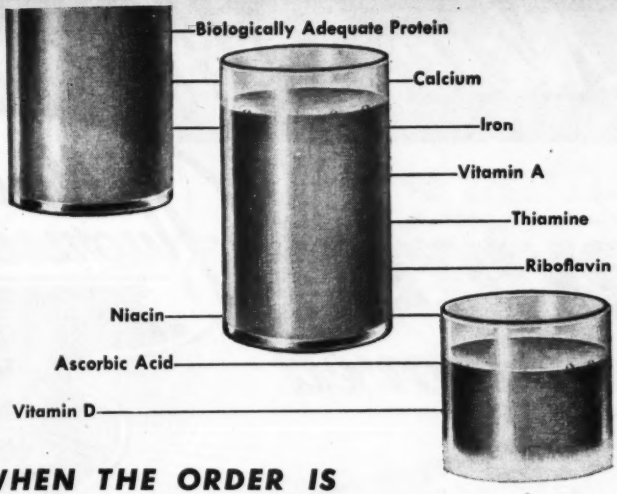
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Of course, they're a specific ℞ for Vincent's. The book says: 

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When extensive oral surgery, maxillofacial trauma, gum infection, or exodontia makes mastication impossible and solid foods offending, a well formulated liquid diet is specially indicated.

Satisfaction of nutrient demands is necessary to promote best possible healing of the involved tissues until normal mastication is again possible. The food drink made by mixing Ovaltine with milk is a valuable component of any liquid diet. Its delicious taste encourages its consumption in recommended quantities. It supplies nutrients of particular value in a liquid diet: B complex vitamins, vitamins A and D, ascorbic acid and biologically complete protein. The generous contribution of these nutrients as well as the others provided by this dietary supplement, appear in the table of composition.

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Ovaltine

Three servings daily of Ovaltine, each made of ½ oz. of Ovaltine and 8 oz. of whole milk,* provide:

CALORIES	669	VITAMIN A	3000 I.U.
PROTEIN	32.1 Gm.	VITAMIN B_1	1.16 mg.
FAT	31.5 Gm.	RIBOFLAVIN	2.00 mg.
CARBOHYDRATE	64.8 Gm.	NIACIN	6.8 mg.
CALCIUM	1.12 Gm.	VITAMIN C	30.0 mg.
PHOSPHORUS	0.94 Gm.	VITAMIN D	417 I.U.
IRON	12.0 mg.	COPPER	0.50 mg.

*Based on average reported values for milk.

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CONTENTS:
4 full portion powders (1 each Nos. 15, 16, 21, 24)
1 full portion bottle of liquid
1 Zinc Silicate and Kryptex Improved Color Guide
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VALUE $10.50 PRICE $7.50

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operations, particula
where accurate color va
translucence and flu
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cementing porcelain
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...r supplied with 2 added ...rs: No. 15 white and No. ...luish gray.

...cated for posterior fill- ...; cervical, proximal and ...cavities in bicuspids and ...ars in permanent and ...iduous teeth.

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1 each full portion powders Nos. 15, 18, 21, 24
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PRICE **$7.50**

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STRICTLY IMPERSONAL

But to most people a "session" with the dentist is at best an ordeal.

It can be made less trying and distasteful by the use of Lavoris before, during and after operating.

Try it and see how many express their appreciation.

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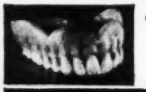
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New formula Solvi-Dent Bur Cleaner and Solvi-Dent cleaner for diamond points are quick-acting, thorough, and convenient. Solvi-Dent solutions keep burs and diamond points clean, bright, sanitary and add greatly to their cutting life.

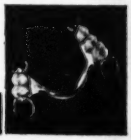
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applied like nail polish contains extract of capsicum (2.34) in a base of acetone nail lacquer and isopropyl



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$1 per bottle at your dental supply house

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to a

Frequent Question

EVERY dentist is asked, many times, if there is a good dentifrice that doesn't cost too much. A helpful answer is to suggest a product which the dentist himself often uses in a variety of ways—bicarbonate of soda, widely known as baking soda.

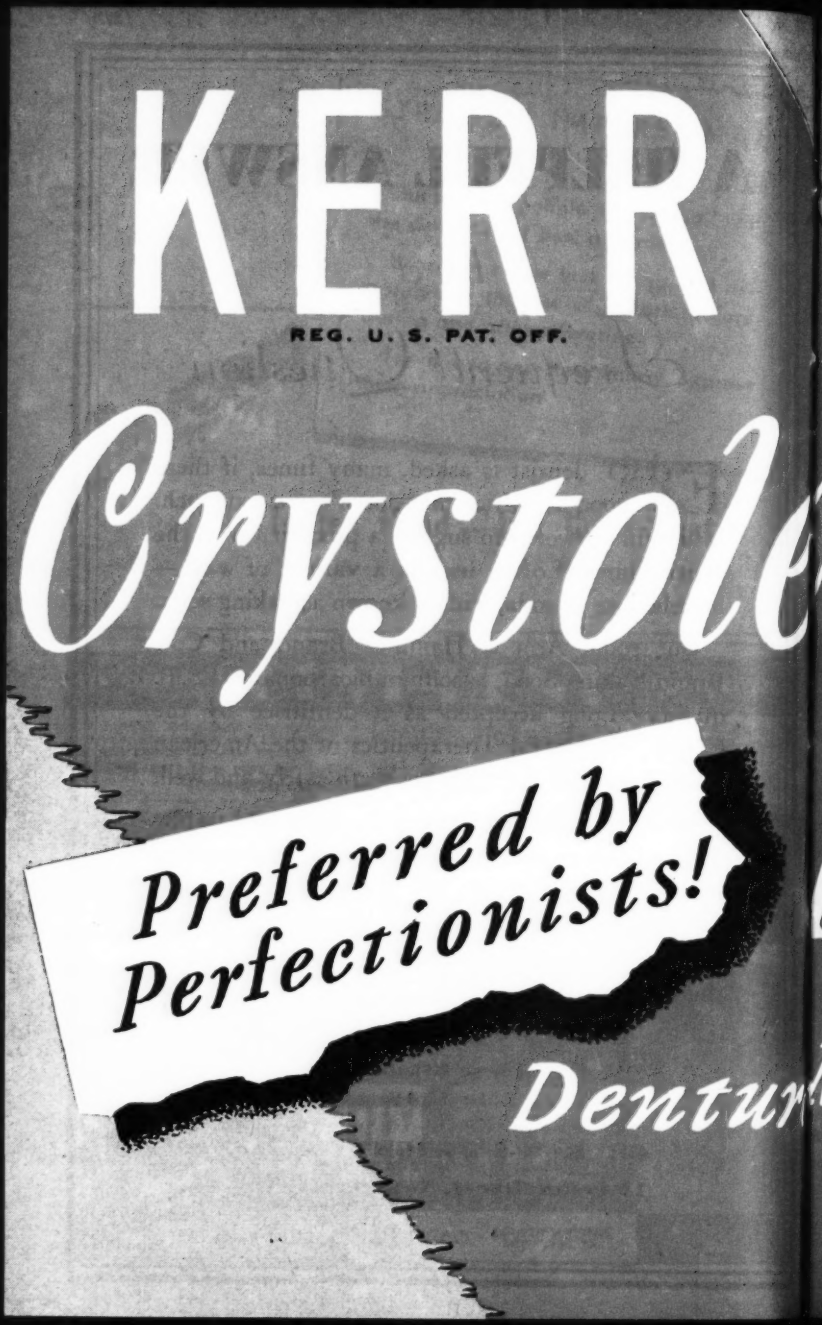
Our soda, Arm & Hammer Brand and Cow Brand Baking Soda, is sodium bicarbonate U.S.P. quality. Long accepted as a dentifrice by the Council on Dental Therapeutics of the American Dental Association, it cleans teeth safely and well.

Because of the low cost of our soda and its dependable character, the dentist will be rendering real service to his patients when he recommends it as a dentifrice. Sold in convenient sealed containers, it is available practically everywhere in the United States.

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Among all the dentists
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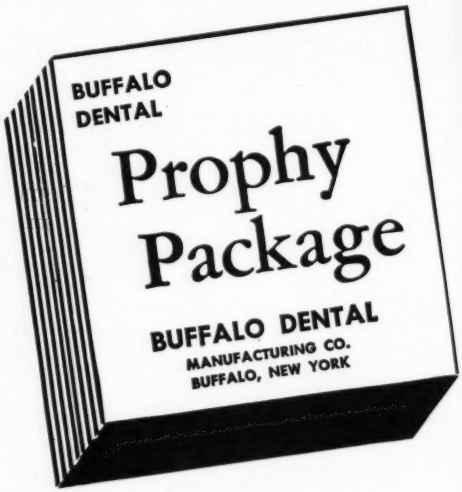
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STERODENT

PROPHYLAXIS PASTE

COSTS LITTLE ★ WORKS FAST



RISING COSTS of office operation can be partly offset by conserving your time. Efficient Sterodent Cleanser saves three ways; low cost, prepared ready to use, rapid cleansing and polishing action in one operation. Approximately a penny per patient for this excellent cleanser!

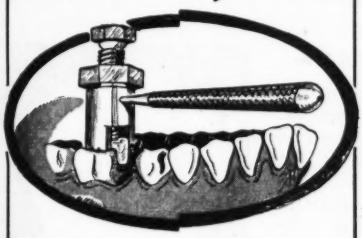
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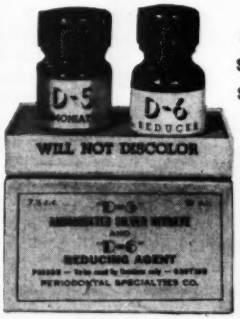
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Write for information and technic on these and other "D" formulas.

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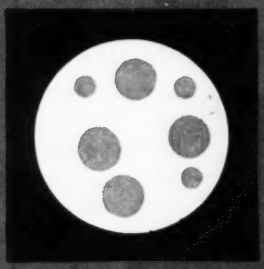
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THE FIRST IMPORTANT ADVANCE IN AN

acrylic denture resin

SINCE THE INTRODUCTION OF THE POWDER AND LIQUID METHOD TEN YEARS AGO.

The Color Is Locked In



LOKTONE

In these drawings from photomicrographs (magnified 1000 X) note how the pigment of Loktone is actually locked within the tiny spherical granule.

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Most dramatic of the many improvements incorporated in Loktone is the locked-in color which prevents "running" and streaking, provides unequalled color dependability.



OTHERS

In the typical denture base material granule the pigment is in the form of a relatively insecure coating on the outside surface.

LOKTONE IS *NEW* LOKTONE IS *DIFFEREN*

LOCKED-IN color is but one of many advantageous features presented in this remarkable new material. In addition Loktone...

LOOKS MORE NATURAL — has a new variegated tissue-like appearance exclusive with Loktone because it depends on its unique structure.

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SAVES TIME AND LABOR — no stirring is required in mixing, it practically mixes itself and remains workable longer.

AND HAS BETTER FINAL PHYSICAL PROPERTIES — mixing without stirring and no mineral color layers to interfere with the "wedding" of the polymer and monomer contribute to greater density, toughness and dimensional stability.

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at no risk to you

Mail this coupon for one laboratory-size package of Loktone (sufficient for ten average cases) at $15.00.

With this package, you will receive FREE, a smaller trial package. If, after using this smaller sample, you are not convinced of Loktone's superior qualities, you may return the large package (unopened) for full credit.

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OKTONE IS *BETTER*

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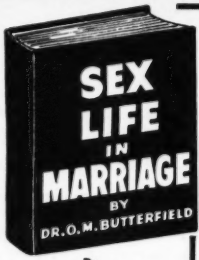
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- Conforms to Federal & A.D.A. Specifications

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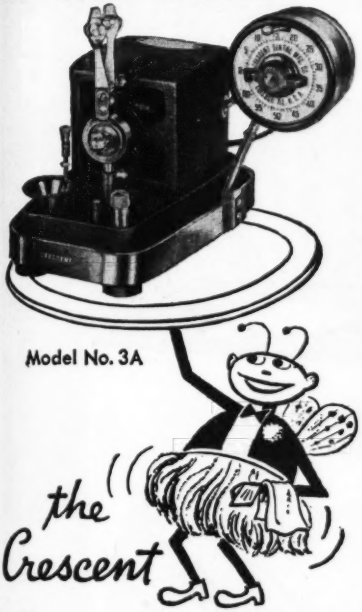
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the Crescent

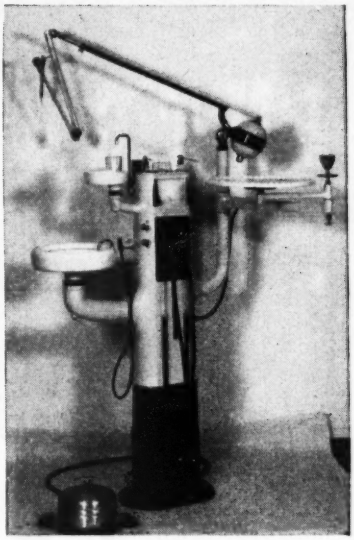
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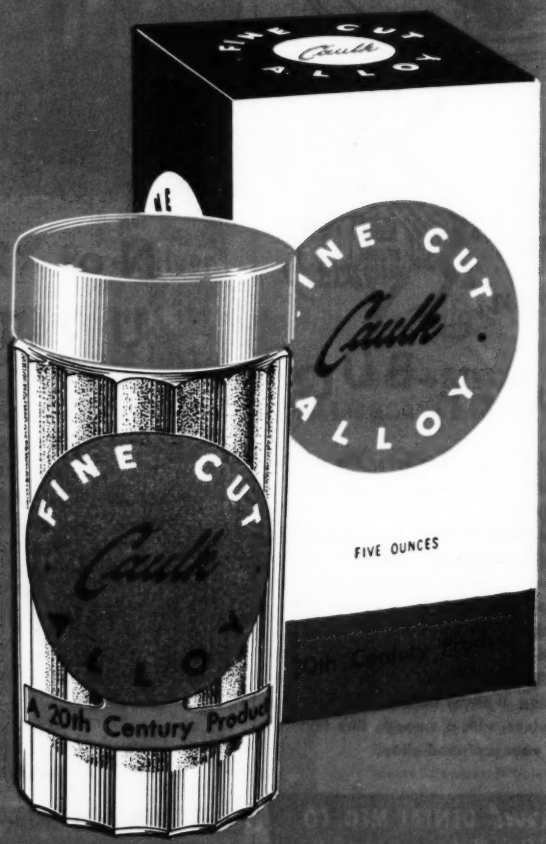
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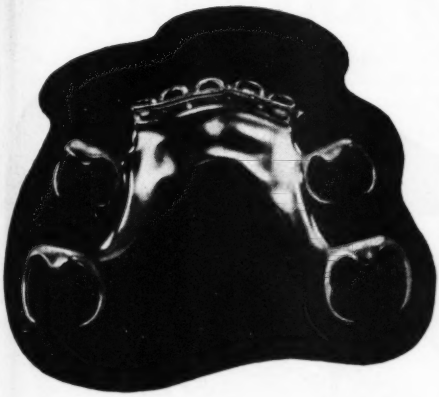


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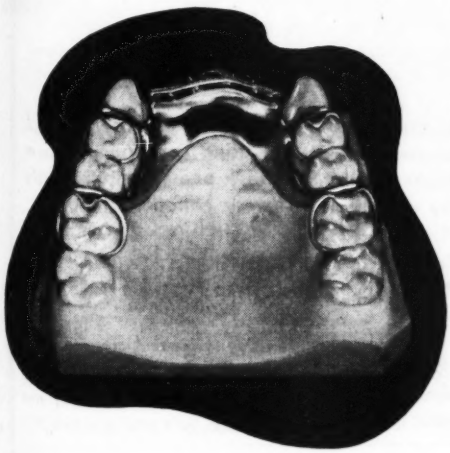
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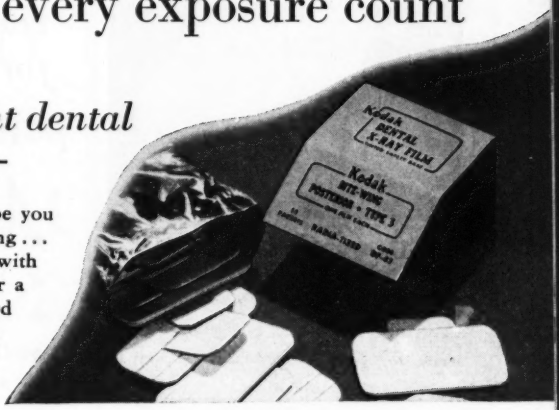
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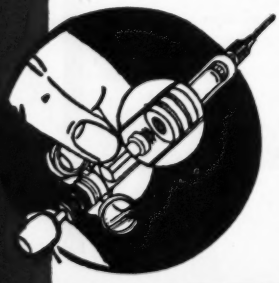


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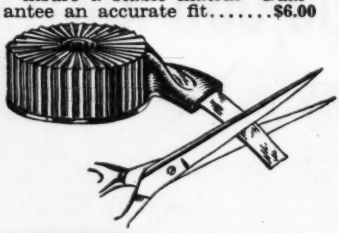
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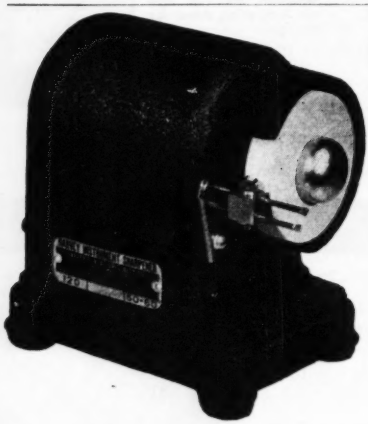
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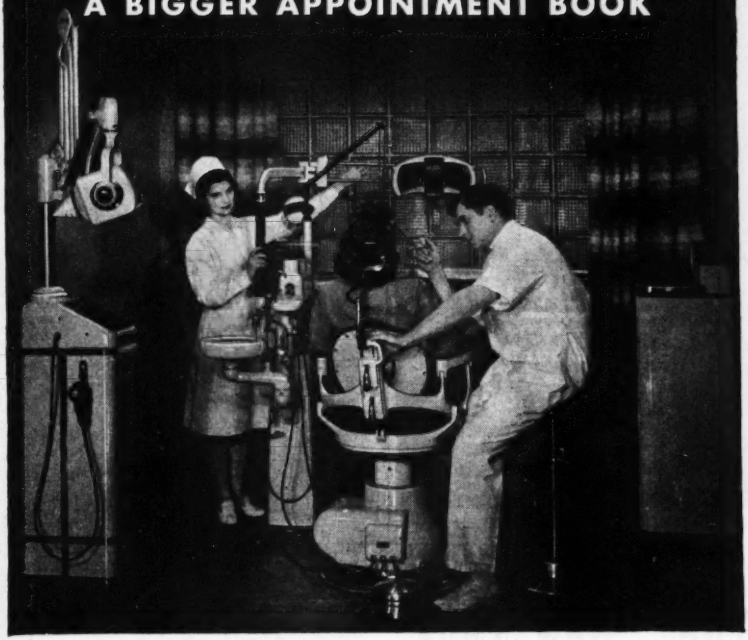
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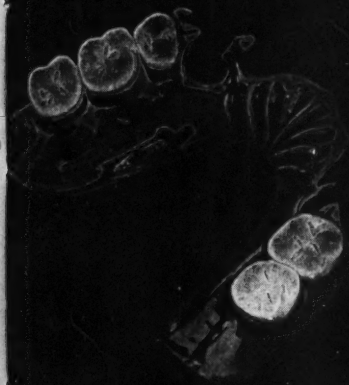
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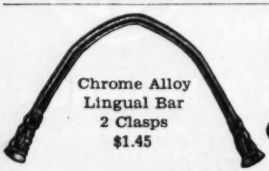
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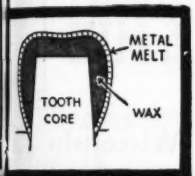
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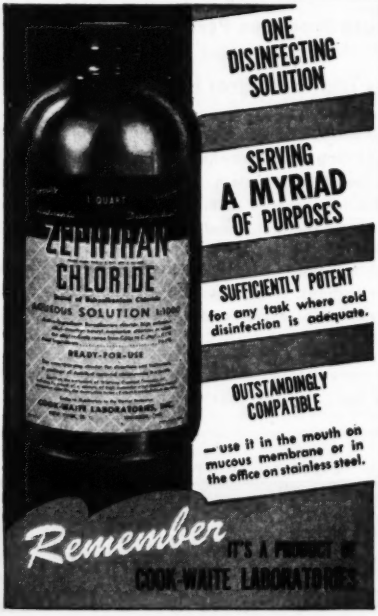
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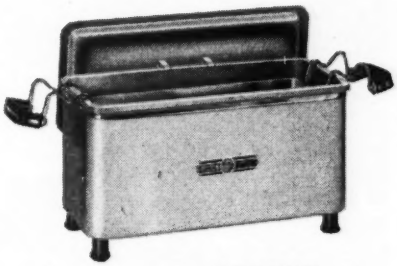
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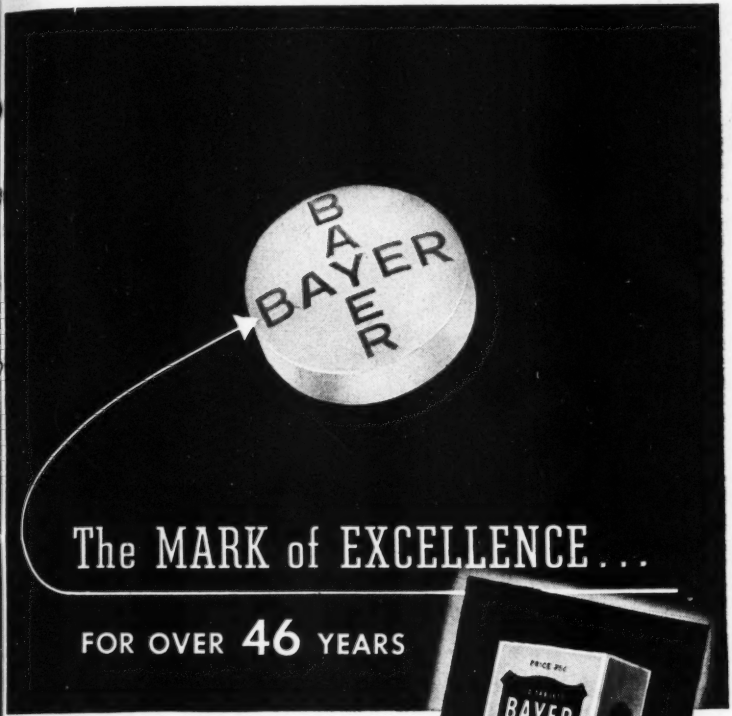
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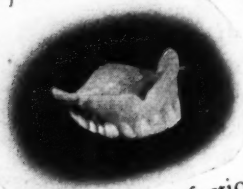
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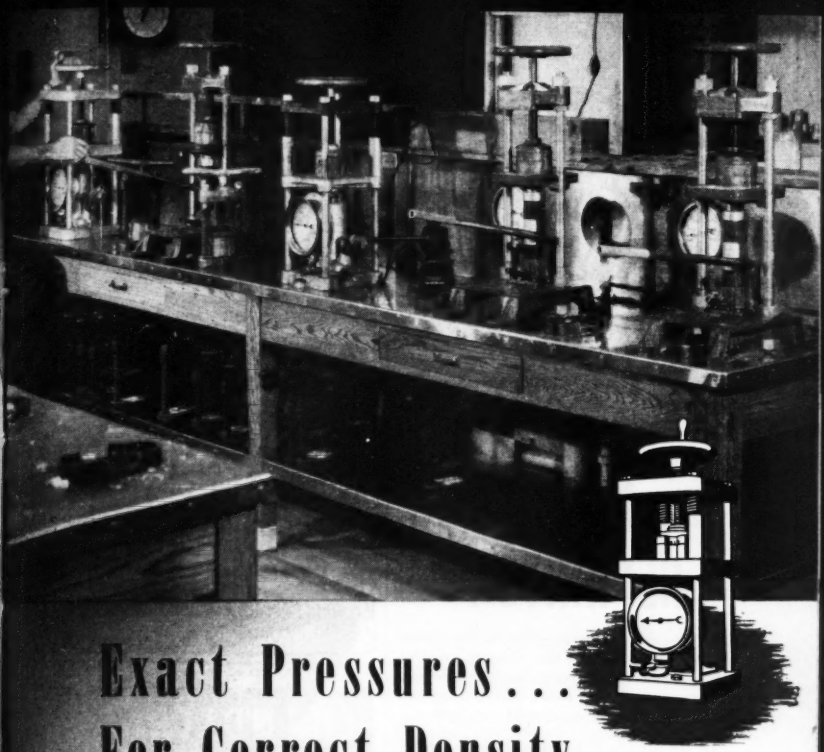
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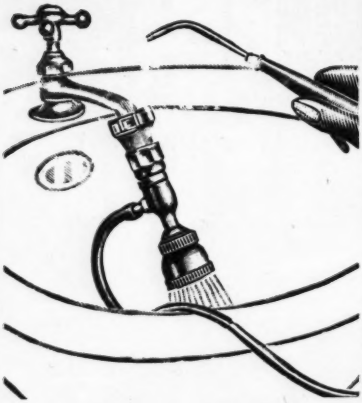
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Recent histopathological research[1, 5] in the etiology of dental caries supports the concept advanced by Dr. Bernhard Gottlieb[2] . . . that the pathogenesis is primarily a proteolysis of the organic substance of the tooth . . . the result of penetration by microorganisms through the organic tracts of the enamel, principally the lamellae.

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. . . the convenient, ready to use unit contains the impregnating solutions based upon the research of Dr. Bernhard Gottlieb and conforms to the latest development in formulation.



BIBLIOGRAPHY . . . (1) Gottlieb B., Diamond M. and Applebaum E., Am. Jr. of Orthodontics & Oral Surg., V 32, No. 6, P 365-379, June 1946. (2) Gottlieb B., Ztschr. f. Stomatol, 19: 129, 1921. (3) Gottlieb B. and Hinds E., Jr. Dent. Res. 21, 317, 1942. (4) Younger H., Freeman Clinic for Children, Dallas, Tex. (5) Frisbie, H. E. and Nuckolls, J., Jr. Dent. Res., 26: 181, 1947.

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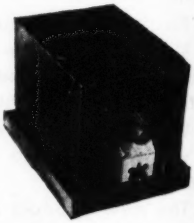
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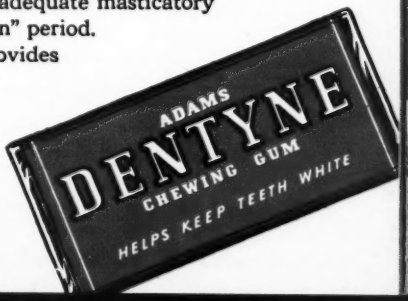


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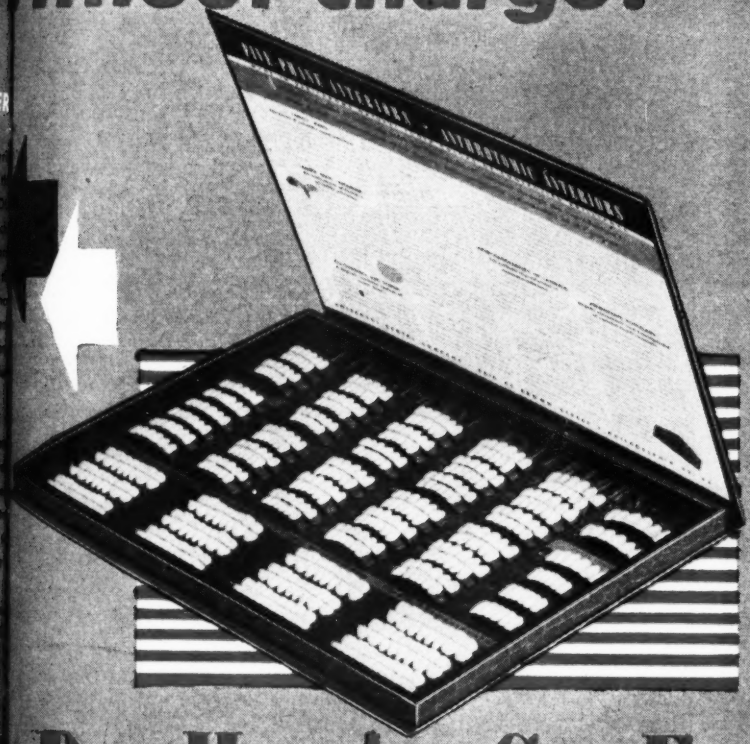
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WHO'S WHO AND WHERE

ADVERTISING INDEX

Although we aim for accuracy in this index, last-minute changes often alter page numbers and positions

Abbott Laboratories 1269
Aderer, Inc., Julius 1206-07
Adopta-Hobby, Inc. 1280
Allison Co., W. D. 1318
American Cabinet Co. 1216
American Chicle Co. 1337
Arco Pharmaceuticals, Inc. 1328
Austenal Laboratories, Inc. 1218-19

Baker & Co., Inc. 1208, 1276
Baldor Electric Co. 1320
Bayer Co. 1325
Bendick Co. 1320
Boos Dental Laboratories, Inc., Henry P. .1326-27
Bristol Laboratories 1329
Bristol-Myers Co. .....1209, 4th cover
Buffalo Dental Mfg. Co. 1294

Camel Cigarettes 1212
Castle Co., Wilmot 1283
Caulk Co., The L. D. 1300-01
Central Dental Mfg. Co. 1299
Chandler Co., H. M. 1328
Chicago Wheel & Mfg. Co. 1282
Church & Dwight Co., Inc. 1291
Cleveland Dental Mfg. Co. .....2nd cover
Coago 1336
Coe Laboratories, Inc. 1217
Colwell Publishing Co. 1318
Commercial Solvents Corp. 1270
Cook-Waite Laboratories, Inc. 1277, 1280, 1284-85, 1322, 1334
Corega Chemical Co. 1343
Crescent Dental Mfg. Co. 1282, 1298-99, 1308
Cutter Laboratories 1286

Dee, Division of Handy and Harman 1226
DeMaria Co. 1312
Dental Absorbents Co. 1282, 1302
Dental Perfection Co. 1330-31
Denticator Co. 1267
Dentists' Supply Co., The 1205
Dentyne Gum 1337
Dewey School of Orthodontia 1322
Dresch Laboratories Co. 1278
Drucker Co., August E. 1311
Durallium Products Corp. 1203

Eastman Kodak Co. 1307
Emerson Books, Inc. 1298

Forhan Co. 1228
FR Corporation 1268

General Electric X-Ray Corp. 1210-11
Getz Corp., William, The 1335
Glazbrook Bros. 1312
Goldsmith Bros. Smelting & Refining Co. .1319

Haack Laboratories, Inc. 1302
Halford Laboratories 1336
Handpiece Glove Co. 1328
Harvey Dental Specialty Co. 1316
Hatch Co., B. C. 1312
Hoffmann-LaRoche, Inc. 1313
Hoover Uniforms 1308
Hudson Products, Inc. 1227
Hu-Friedy Mfg. Co. 1328

International Nickel Co., Inc. 1303

Jelenko & Co., Inc., J. F. 1318
Johnson & Johnson 1304
Justi & Son, Inc., H. D. 1265

Kerr Mfg. Co. .....
Kolynos .....
Konformax Division, Permatex Co., Inc. .....

Lang Dental Mfg. Co. .....
Lauer Metal Shop .....
Lavoris Co. .....
LeDent Mfg. Co. .....

Masel Co., Isaac .....
Master Appliance Co. .....
McKesson Appliance Co. .....
Minimax Co. .....
Mizzy, Inc. .....
Moyer Co., J. Bird .....
Mullen Bros. .....
Myerson Tooth Corp. .....

National Confectioners' Ass'n. .....
National Synthetics Inc. .....
Nelson, Dr. A. A. .....
Ney Co., J. M. .....
Nobilium Products, Inc. .....
Novocol Chemical Mfg. Co. .....
Num Specialty Co. .....

Ohio Chemical Mfg. Co. .....
Ovaltine .....

Pelton & Crane Co., The .....
Periodontal Specialties Co. .....
Pfingst Co., Inc. .....
Pittsburgh Specialty Co. .....
Polident .....
Precious Metals Research Works .....
Professional Printing Co. .....
Prometheus Electric Corp. .....
Prophylactic Brush Co. .....

Reynolds Tobacco Co., R. J. .....
Rinn X-Ray Products, Inc. .....
Ritter Co., Inc. .....
Rocky Mountain Metal Products Co. .....
Rose, David .....
Rystan Co., Inc. .....

Schneider, M. W. .....
Sekine Co., Inc. .....
Silvodent Co., The .....
Solvident Co. .....
Specialty Products Co. .....
Spyco Smelting & Refining Co. .....
Sterile Products Co. .....
Stim-U-Dents .....

Torit Mfg. Co. .....

Union Broach Co. .....
Universal Dental Co. .....
Urell, Inc. .....

Vernon-Benshoff Co. .....
Vize, Dr. James Leroy .....

Wander Co. .....
Warner & Co., Inc., William R. .....
Weber Dental Mfg. Co. .....
Wernet Dental Mfg. Co. .....
Western Gold & Platinum Works .....
White Dental Mfg. Co., The S. S. .....
Whitehall Pharmacal Co. .....
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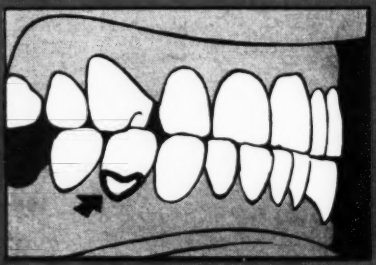
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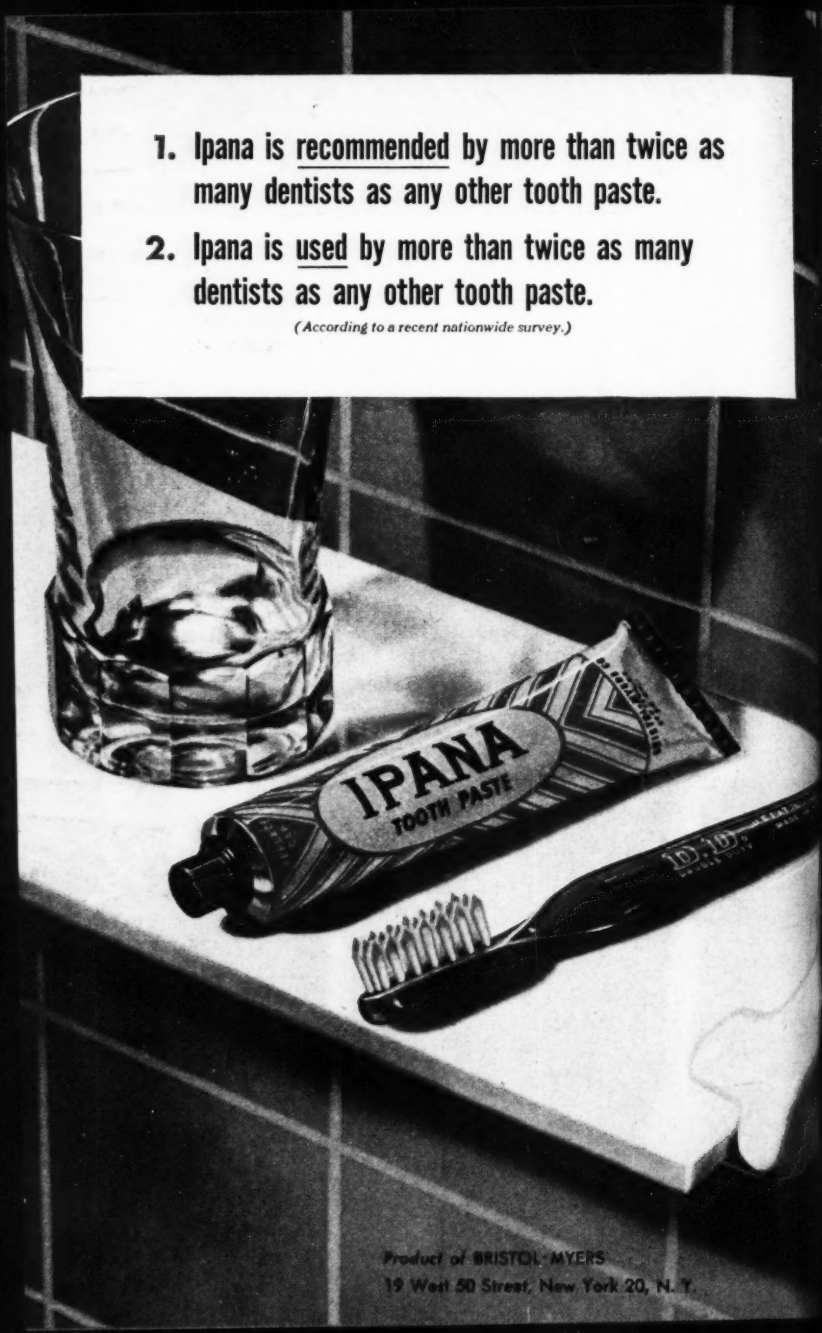
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